DOCKET

SUPREME COURT
OF THE UNITED STATES

No. 11-400
Vide 11-393
Title: Florida, et al., Petitioners
v.
Department of Health and Human Services, et al.
Docketed: September 29, 2011
Lower Ct: United States Court of Appeals for the Eleventh Circuit
Case Nos.: (11-11021, 11-11067)
Decision Date: August 12, 2011
Questions Presented

~~Date~~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~
Sep 27 2011	Petition for a writ of certiorari filed. (Response due October 31, 2011)
Sep 27 2011	Appendix of Florida, et al. filed.
Oct 7 2011	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for the Private Respondents. VIDED.
Oct 11 2011	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for the respondents, the Solicitor General. VIDED.
Oct 11 2011	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for State Petitioners, Florida, et al. VIDED.
Oct 14 2011	Waiver of right of respondents National Federation of Independent Business, et al. to respond filed.
Oct 17 2011	Brief of respondents Department of Health and Human Services, et al. filed. VIDED.
Oct 24 2011	Reply of petitioner Florida, et al. filed.
Oct 25 2011	Brief amicus curiae of America's Health Insurance Plans filed. VIDED.
Oct 25 2011	Brief amicus curiae of Chamber of Commerce of the United States of America filed. VIDED.
Oct 25 2011	Brief amici curiae of Association of American Physicians and Surgeons, et al. filed.
Oct 26 2011	DISTRIBUTED for Conference of November 10, 2011.
Oct 26 2011	Brief amici curiae of American Center for Law and Justice, et al. filed. (Distributed)
Oct 27 2011	Brief amici curiae of Family Research Council, et al. filed. VIDED. (Distributed)
Oct 31 2011	Brief amici curiae of Center for Constitutional Jurisprudence, et al. filed. (Distributed)
Oct 31 2011	Brief amicus curiae of Lawrence J. Dickson, Ph.D. filed. (Distributed)
Nov 14 2011	Petition GRANTED limited to the issue of severability presented by Question 3 of the petition. The petition for a writ of certiorari in No. 11-393 is granted. The cases are consolidated and a total of 90 minutes is allotted for oral argument.
Nov 14 2011	Petition GRANTED limited to Question 1 presented by the petition.

Nov 15 2011	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for the respondents, the Solicitor General. VIDED
Nov 16 2011	Consent to the filing of amicus curiae briefs in support of either party or neither party received from counsel for the National Federation of Independent Business, et al. VIDED
Nov 18 2011	H. Bartow Farr, III, Esquire, of Washington, D.C., is invited to brief and argue these cases, as amicus curiae, in support of the judgment of the Court of Appeals that the minimum coverage provision of the Patient Protection and Affordable Care Act, 26 U.S.C. 5000A, is severable from the entirety of the remainder of the Act. VIDED
Nov 22 2011	Consent to the filing of amicus curiae briefs, in support of either party or neither party, received from counsel for Florida, et al. VIDED
Dec 3 2011	Motion for leave to intervene filed by Freedom Watch. VIDED.
Dec 5 2011	Briefing proposal of the parties and Court-appointed amici curiae filed. VIDED
Dec 6 2011	Motion DISTRIBUTED for Conference of December 9, 2011.
Dec 7 2011	Letter from counsel for National Federation of Independent Business, et al. regarding Mary Brown received. (Distributed). VIDED
Dec 8 2011	Upon consideration of the letter of December 5, 2011, from the Solicitor General on behalf of the parties and the amici curiae invited to brief and argue these cases, the following briefing schedule is adopted. On the Minimum Coverage Provision issue (No. 11-398), the brief of the Solicitor General, not to exceed 16,500 words, is to be filed on or before Friday, January 6, 2012. The briefs of respondents, not to exceed 16,500 words, are to be filed on or before Monday, February 6, 2012. The reply brief, not to exceed 6,600 words, is to be filed on or before Wednesday, March 7, 2012. On the Anti-Injunction Act issue (No. 11-398), the brief of the Court-appointed amicus curiae is to be filed on or before Friday, January 6, 2012. The briefs of the Solicitor General and respondents are to be filed on or before Monday, February 6, 2012. Reply briefs of the Solicitor General and respondents are to be filed on or before Monday, February 27, 2012. The reply brief of the Court-appointed amicus curiae is to be filed on or before Monday, March 12, 2012. VIDED
Dec 8 2011	On the Severability issue (Nos. 11-393 and 11-400), the briefs of petitioners are to be filed on or before Friday, January 6, 2012. The brief of the Solicitor General is to be filed on or before Friday, January 27, 2012. The brief of the Court-appointed amicus curiae is to be filed on or before Friday, February 17, 2012. Reply briefs of the Solicitor General and petitioners are to be filed on or before Tuesday, March 13, 2012. On the Medicaid issue (No. 11-400), the brief of petitioners is to be filed on or before Tuesday, January 10, 2012. The brief of the Solicitor General is to be filed on or before Friday, February 10, 2012. The reply brief is to be filed on or before Monday, March 12, 2012. Other amici curiae shall file separate briefs on each issue they intend to address. The briefs shall be filed within the time allowed under Rule 37.3(a) of the Rules of this Court, except that amici curiae briefs addressing the Severability issue shall be filed on or before the due date for the brief of the party or Court-appointed amicus curiae whose position the brief is supporting. The parties and amici curiae shall identify on the cover of each brief the issue that is addressed in the brief. Amici curiae shall also identify on the cover of the brief the party or parties supported or whether the brief suggests affirmance or reversal, as required by Rule 37.3(a) of the Rules of this Court. VIDED
Dec 12 2011	Motion for leave to intervene filed by Freedom Watch DENIED.
Dec 19 2011	SET FOR ARGUMENT ON Wednesday, March 28, 2012 (Severability). VIDED
Dec 19 2011	SET FOR ARGUMENT ON Wednesday, March 28, 2012 (Medicaid).
Jan 4 2012	Motion to add parties Dana Grimes and David Klemencic as additional petitioners in No.

	11-393 and additional respondents in Nos. 11-398 and 11-400 filed by respondents National Federation of Independent Business, et al. VIDED.
Jan 4 2012	Brief amicus curiae of American Civil Rights Union (Severability Issue) filed. VIDED.
Jan 5 2012	Brief amicus curiae of Freedom Watch filed. VIDED.
Jan 5 2012	Motion of Freedom Watch for leave to participate in oral argument as amicus curiae and for divided argument filed. VIDED.
Jan 6 2012	Joint appendix (Minimum Coverage Provision, Anti-Injunction Act, and Severability) filed. VIDED. (Statement of costs filed)
Jan 6 2012	Brief of petitioners in No. 11-393, National Federation of Independent Business, et al. (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amici curiae of American Hospital Association, et al. (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amicus curiae of Chamber of Commerce of the United States of America (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief of petitioners Florida, et al. (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amici curiae of America's Health Insurance Plans and The Blue Cross Blue Shield Association (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amici curiae of American Center for Law and Justice, et al. (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amicus curiae of National Restaurant Association (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amici curiae of Family Research Council, et al. (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amicus curiae of Justice and Freedom Fund (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amicus curiae of United States Senate (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amici curiae of Association of American Physicians and Surgeons, et al. (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amici curiae of Economists (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amici curiae of Competitive Enterprise Institute, et al. (Severability) filed. VIDED. (Distributed)
Jan 6 2012	Brief amici curiae of Texas Public Policy Foundation and Cato Institute (Severability) filed. VIDED. (Distributed)
Jan 9 2012	Motion DISTRIBUTED for Conference of January 13, 2012.
Jan 9 2012	Record received from U.S.C.A. for 11th Circuit. (1 box)
Jan 10 2012	Brief of petitioners Florida, et al. (Medicaid) filed. (Distributed)
Jan 10 2012	Joint appendix (Medicaid) filed.
Jan 11 2012	CIRCULATED
Jan 12 2012	Record received from U.S.D.C. for Northern District of Florida. (1 box) The remainder of the record is electronic.
Jan 17 2012	Motion to add parties Dana Grimes and David Klemencic as additional petitioners in No. 11-393 and additional respondents in Nos. 11-398 and 11-400 filed by respondents National Federation of Independent Business, et al. GRANTED.
Jan 17 2012	Brief amici curiae of Center for Constitutional Jurisprudence, et al. (Medicaid) filed. (Distributed)

Jan 17 2012	Brief amici curiae of Indiana Legislators, et al. (Medicaid) filed. (Distributed)
Jan 17 2012	Brief amici curiae of American Civil Rights Union, et al. (Medicaid) filed. (Distributed)
Jan 17 2012	Brief amicus curiae of James F. Blumstein (Medicaid) filed. (Distributed)
Jan 17 2012	Brief amici curiae of Economists (Medicaid) filed. (Distributed)
Jan 17 2012	Brief amicus curiae of Independence Institute (Medicaid) filed. (Distributed)
Jan 17 2012	Brief amici curiae of Association of American Physicians and Surgeons, et al. (Medicaid) filed. (Distributed)
Jan 17 2012	Brief amici curiae of Texas Public Policy Foundation and 36 Texas State Legislators (Medicaid) filed. (Distributed)
Jan 23 2012	Motion of Freedom Watch for leave to participate in oral argument as amicus curiae and for divided argument DENIED. Justice Kagan took no part in the consideration or decision of this motion.
Jan 27 2012	Brief of respondents Department of Health and Human Services, et al. (Severability) filed. VIDED. (Distributed)
Jan 27 2012	Brief amici curiae of California, et al. (Severability) filed. VIDED. (Distributed)
Jan 27 2012	Brief amici curiae of American Public Health Association, et al. (Severability) filed. VIDED. (Distributed)
Jan 27 2012	Brief amici curiae of AARP, et al. (Severability) filed. VIDED. (Distributed)
Jan 27 2012	Brief amicus curiae of American Academy of Actuaries (Severability) filed. VIDED. (Distributed)
Jan 27 2012	Brief amici curiae of Michigan Legal Services, Inc., et al. (Severability) filed. VIDED. (Distributed)
Jan 27 2012	Brief amici curiae of National Indian Health Board, et al. (Severability) filed. VIDED. (Distributed)
Jan 27 2012	Brief amici curiae of American Medical Student Association, et al. (Severability) filed. VIDED. (Distributed)
Jan 27 2012	Brief amicus curiae of American Benefits Council (Severability) filed. VIDED. (Distributed)
Jan 30 2012	Motion for reconsideration for leave to participate in oral argument as amicus curiae and for divided argument filed. VIDED. filed by Freedom Watch. VIDED.
Feb 3 2012	Motion for divided argument and enlargement of time for oral argument on the Anti-Injunction Act issue filed by respondents Kathleen Sebelius, Secretary of Health and Human Services, et al., joined by both Court-appointed counsel. VIDED.
Feb 3 2012	Motion for divided argument and enlargement of time for oral argument on the Anti-Injunction Act issue filed by Florida, et al. and National Federation of Independent Business, et al. VIDED.
Feb 6 2012	Brief amicus curiae of Missouri (Severability) filed. VIDED. (Distributed)
Feb 10 2012	Brief of respondent Department of Health and Human Services, et al. (Medicaid) filed. (Distributed)
Feb 15 2012	Brief amici curiae of David R. Riemer and Community Advocates (Medicaid) filed. (Distributed)
Feb 15 2012	Brief amici curiae of David R. Riemer and Community Advocates (Severability) filed. VIDED. (Distributed)
Feb 15 2012	Brief amici curiae of National Health Law Program, et al. (Medicaid) filed. (Distributed)
Feb 15 2012	Brief amicus curiae of The Washington and Lee University School of Law Black Lung Clinic (Severability) filed. VIDED. (Distributed)

Feb 17 2012	Brief amici curiae of Asian & Pacific Islander American Health Forum, et al. (Severability) filed. VIDED. (Distributed)
Feb 17 2012	Brief amici curiae of State Legislators from the Fifty States, et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of National Minority Aids Council, et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Senate Majority Leader Harry Reid, et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Service Employees International Union, et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Catholic Sisters (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Health Law & Policy Scholars and Prescription Policy Choices (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of David Satcher, M.D., Ph.D., et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Oregon, et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of American Hospital Association, et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Joella Swan, et al. (Severability) filed. VIDED. (Distributed)
Feb 17 2012	Brief amicus curiae of Court-appointed amicus curiae (Severability) filed. VIDED. (Distributed)
Feb 17 2012	Brief amicus curiae of Disability Rights Legal Center (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Michigan Legal Services, Inc., et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Faithful Reform in Health Care, et al. (Medicaid) filed. (Distributed)
Feb 17 2012	Brief amici curiae of Leadership Council on Civil and Human Rights, et al. (Medicaid) filed. (Distributed)
Feb 21 2012	Upon consideration of the motions pertaining to the allocation of oral argument time, the following allocation of oral argument time is adopted. On the Anti-Injunction Act issue (No. 11-398), the Court-appointed amicus curiae is allotted 40 minutes, the Solicitor General is allotted 30 minutes, and the respondents are allotted 20 minutes. On the Minimum Coverage Provision issue (No. 11-398), the Solicitor General is allotted 60 minutes, respondents Florida, et al. are allotted 30 minutes, and respondents National Federation of Independent Business, et al. are allotted 30 minutes. On the Severability issue (Nos. 11-393 and 11-400), the petitioners are allotted 30 minutes, the Solicitor General is allotted 30 minutes, and the Court-appointed amicus curiae is allotted 30 minutes.On the Medicaid issue (No. 11-400), the petitioners are allotted 30 minutes, and the Solicitor General is allotted 30 minutes.
Feb 27 2012	Motion for reconsideration of order denying leave to participate in oral argument as amicus curiae and for divided argument filed by Freedom Watch DENIED. Justice Kagan took no part in the consideration or decision of this motion. VIDED.
Mar 12 2012	Reply of petitioners Florida, et al.(Medicaid) filed. (Distributed)
Mar 13 2012	Reply of respondents Department of Health and Human Services, et al. (Severability) filed. VIDED. (Distributed)
Mar 13 2012	Reply of petitioners in No. 11-393, National Federation of Independent Business, et al. filed. (Severability) VIDED. (Distributed)
Mar 13 2012	Reply of petitioners Florida, et al. (Severability) filed. VIDED. (Distributed)
Mar 14 2012	Letter from the Solicitor General proposing to lodge 10 copies of the Government Printing Office s Compilation of the Patient Protection and Affordable Care Act. (Distributed)

Mar 15 2012	Proposal from Court-appointed amicus counsel to lodge copies of a report by the Rand Foundation, "The Effect of the Affordable Care Act on Enrollment and Premiums, With and Without the Individual Mandate." VIDED.
Mar 17 2012	Motion for leave to intervene, in support of Court-appointed amicus on the issue of severability, filed by David Boyle. VIDED.
Mar 28 2012	Motion DISTRIBUTED for Conference of April 13, 2012.
Mar 28 2012	Argued. (Severability) For petitioners: Paul D. Clement, Washington, D. C. For respondents: Edwin S. Kneedler, Deputy Solicitor General, Department of Justice, Washington, D. C. For Court-appointed amicus curiae: H. Bartow Farr, III, Washington, D. C.
Mar 28 2012	Argued. (Medicaid Expansion) For petitioners: Paul D. Clement, Washington, D. C. For respondents: Donald B. Verrilli, Jr., Solicitor General, Department of Justice, Washington, D. C.
Mar 29 2012	Letter and attachment from counsel for the petitioners Florida, et al. filed. (Distributed)
Apr 16 2012	Motion for leave to intervene filed by David Boyle DENIED. VIDED.
Apr 25 2012	Letter received from National Federation of Independent Business (Distributed)
May 7 2012	Motion for reconsideration of motion for leave to intervene, in support of Court-appointed amicus on the issue of severability filed by David Boyle. VIDED.
May 22 2012	Motion DISTRIBUTED for Conference of June 7, 2012.
Jun 11 2012	Motion of David Boyle for reconsideration of motion for leave to intervene DENIED. VIDED

PETITION
FOR
WRIT OF
CERTIORARI

NO. _____

In the
Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTAD, GOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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PETITION FOR WRIT OF CERTIORARI

SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

September 27, 2011

(Additional Counsel Listed on Inside Cover)

JOHN W. SUTHERS
Attorney General
of Colorado
1525 Sherman Street,
Denver, CO 80203

THOMAS W. CORBETT, JR.
Governor
LINDA L. KELLY
Attorney General
Commonwealth of
Pennsylvania
16th Floor
Strawberry Square
Harrisburg, PA 17120

MARTY J. JACKLEY
Attorney General
of South Dakota
1302 East Highway 14
Pierre, SD 57501

GREGORY F. ZOELLER
Attorney General of Indiana
302 West Washington Street
Indianapolis, IN 46204

BRIAN SANDOVAL
Governor of Nevada
State Capitol Building
101 North Carson Street
Carson City, NV 89701

ROBERT M. MCKENNA
Attorney General
of Washington
1125 Washington Street S.E.
P.O. Box 40100
Olympia, WA 98504

JOSEPH SCIARROTTA, JR.
General Counsel
Office of Arizona Governor
JANICE K. BREWER
TOM HORNE
Attorney General of Arizona
1700 West Washington
Street, 9th Floor
Phoenix, Arizona 85007

WAYNE STENEJHEM
Attorney General
of North Dakota
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

LAWRENCE G. WASDEN
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720

BILL COBB
Deputy Attorney General
for Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

PAMELA JO BONDI
Attorney General of Florida
PL-01, The Capitol
Tallahassee, FL 32399

JON BRUNING
Attorney General
of Nebraska
P.O. Box 98920
Lincoln, NE 68509

MARK L. SHURTLEFF
Attorney General of Utah
Capitol Suite #230
P.O. Box 142320
Salt Lake City, UT 84114

LUTHER STRANGE
Attorney General
of Alabama
501 Washington Avenue
Montgomery, AL 36130

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508
(402) 471-2834

ALAN WILSON
Attorney General
of South Carolina
P.O. Box 11549
Columbia, SC 29211

GREG ABBOTT
Attorney General of Texas
P.O. Box 12548
Austin, TX 78711

JAMES D. "BUDDY" CALDWELL
Attorney General
of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804

BILL SCHUETTE
Attorney General
of Michigan
P.O. Box 30212
Lansing, MI 48909

SAMUEL S. OLENS
Attorney General of Georgia
40 Capitol Square, SW
Atlanta, GA 30334

MICHAEL DEWINE
Attorney General of Ohio
30 East Broad Street
17th Floor
Columbus, OH 43215

MATTHEW MEAD
Governor of Wyoming
State Capitol
200 West 24th Street
Cheyenne, WY 82002

WILLIAM J. SCHNEIDER
Attorney General of Maine
Six State House Station
Augusta, ME 04333

JOHN J. BURNS
Attorney General of Alaska
P.O. Box 110300
Juneau, AK 99811

DEREK SCHMIDT
Attorney General of Kansas
Memorial Hall
120 SW 10th Street
Topeka, KS 66612

J.B. VAN HOLLEN
Attorney General of
Wisconsin
114 East State Capitol
Madison, WI 53702

TERRY BRANSTAD
Governor of Iowa
107 East Grand Avenue
Des Moines, IA 50319

QUESTIONS PRESENTED

1. Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress's spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?

2. May Congress treat States no differently from any other employer when imposing invasive mandates as to the manner in which they provide their own employees with insurance coverage, as suggested by *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985), or has *Garcia*'s approach been overtaken by subsequent cases in which this Court has explicitly recognized judicially enforceable limits on Congress's power to interfere with state sovereignty?

3. Does the Affordable Care Act's mandate that virtually every individual obtain health insurance exceed Congress's enumerated powers and, if so, to what extent (if any) can the mandate be severed from the remainder of the Act?

PARTIES TO THE PROCEEDING

Petitioners, who were the appellees/cross-appellants below, are 26 States: Florida, by and through Attorney General Pam Bondi; South Carolina, by and through Attorney General Alan Wilson; Nebraska, by and through Attorney General Jon Bruning; Texas, by and through Attorney General Greg Abbott; Utah, by and through Attorney General Mark L. Shurtleff; Louisiana, by and through Attorney General James D. "Buddy" Caldwell; Alabama, by and through Attorney General Luther Strange; Attorney General Bill Schuette, on behalf of the People of Michigan; Colorado, by and through Attorney General John W. Suthers; Pennsylvania, by and through Governor Thomas W. Corbett, Jr., and Attorney General Linda L. Kelly; Washington, by and through Attorney General Robert M. McKenna; Idaho, by and through Attorney General Lawrence G. Wasden; South Dakota, by and through Attorney General Marty J. Jackley; Indiana, by and through Attorney General Gregory F. Zoeller; North Dakota, by and through Attorney General Wayne Stenehjem; Mississippi, by and through Governor Haley Barbour; Arizona, by and through Governor Janice K. Brewer and Attorney General Thomas C. Horne; Nevada, by and through Governor Brian Sandoval; Georgia, by and through Attorney General Samuel S. Olens; Alaska, by and through Attorney General John J. Burns; Ohio, by and through Attorney General Michael DeWine; Kansas, by and through Attorney General Derek Schmidt; Wyoming, by and through Governor Matthew H. Mead; Wisconsin, by and through Attorney General J.B. Van Hollen; Maine, by and through Attorney General William J. Schneider; and Governor Terry E. Branstad, on behalf of the People of Iowa. The National Federation of Independent Business, Kaj Ahlburg, and Mary Brown were also appellees below.

Respondents, who were the appellants/cross-appellees below, are the U.S. Department of Health & Human Services; Kathleen Sebelius, Secretary, U.S. Department of Health & Human Services; the U.S. Department of Treasury; Timothy F. Geithner, Secretary, U.S. Department of Treasury; the U.S. Department of Labor; and Hilda L. Solis, Secretary, U.S. Department of Labor.

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PETITION FOR CERTIORARI

This case offers this Court an ideal vehicle to resolve pressing and persistent constitutional questions arising out of the Patient Protection and Affordable Care Act. It represents an unprecedented challenge—involving over half the States in the Nation—to an unprecedented legislative initiative. The Act is without precedent both in its coercive impositions on the States and in its effort to force individuals to engage in commerce so that the federal government may regulate them. Both features of the Act raise constitutional issues that go to the heart of our system of limited government and the Constitution's division of authority between the federal government and the States. Of the various challenges working their way through the federal courts, only this case allows the Court to address both of these fundamental questions. And no other case combines the sovereign authority of over half the Nation's States with individuals whose liberty is infringed by the Act's failure to respect limits on the federal government's enumerated powers. That combination ensures that the Court will be able to reach the merits of the critical issues raised in this case. Thus, no matter what the Court does with other cases involving challenges to the Act, it should grant plenary review in this case, and do so expeditiously.

The Act dramatically expands federal regulation of the health care and health insurance industries. It is universal in scope, imposing new obligations on everyone from the States to insurance companies to private employers to individuals. The States challenge three of the Act's core provisions: its significant Medicaid expansions, which Congress has forced upon the States by threatening to withhold billions in federal funding unless States comply; the employer mandates, which impose harsh penalties upon States that do not offer their employees a federally mandated level of insurance; and the Act's individual mandate, which requires nearly all individuals (including those currently eligible for, but not participating in, state-funded Medicaid) to maintain health care insurance or pay a penalty to the federal government. The States maintain that the remainder of the Act cannot stand without those unconstitutional provisions.

The Eleventh Circuit correctly held that the individual mandate is unconstitutional. But it erred in rejecting the States' Medicaid challenge based on a reading of the coercion doctrine that would deprive it of all force as a meaningful limitation on Congress's vast spending power. And the court misapplied this Court's severance doctrine to leave the entire rest of the Act standing even though the mandate indisputably served as the centerpiece of the delicate compromise that produced the Act. Indeed, the Court of Appeals left standing provisions of the Act that even the government conceded were inextricably intertwined with the mandate.

The grave constitutional questions surrounding the ACA and its novel exercises of federal power will not subside until this Court resolves them. Time is of the essence. States need to know whether they must adapt their policies to deal with the brave new world ushered in by the ACA. This case presents the ideal vehicle for the Court to resolve these controversies. The Court should grant plenary review.

OPINIONS BELOW

The Eleventh Circuit's opinion (Pet.App.1) is not yet reported in the Federal Reporter but is available at 2011 WL 3519178. The summary judgment opinion of the District Court for the Northern District of Florida (Pet.App.300) is not yet reported in the Federal Supplement but is available at 2011 WL 285683. The District Court's motion-to-dismiss opinion (Pet.App.402) is reported at 716 F. Supp. 2d 1120.

JURISDICTION

The Eleventh Circuit rendered its decision on August 12, 2011. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The U.S. Constitution's General Welfare Clause, Commerce Clause, Necessary and Proper Clause, and Tenth Amendment are reproduced in the appendix, along with relevant provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (collectively, the "ACA" or "Act"). Pet.App.493–553.

STATEMENT OF THE CASE

A. The Affordable Care Act

The ACA is a massive collection of sweeping changes that impose substantial new federal obligations on every corner of society and compel financial action from nearly every citizen of the

United States. The Act's core provisions work in tandem to increase both supply and demand for health insurance in an attempt to achieve Congress's goal of imposing "near-universal" insurance coverage on the Nation. ACA § 1501(a)(2)(D), (G). The Act also contains hundreds of revenue-raising or cost-cutting provisions intended to help offset the significant new expenses its core provisions will generate.

1. The Individual Mandate and the Insurance Provisions

The ACA mandates that each "applicable individual shall, for each month beginning after 2013, ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month." ACA § 1501(b); 26 U.S.C. § 5000A(a). This mandate to maintain health insurance applies to all individuals except foreign nationals residing here unlawfully, incarcerated individuals, and individuals falling within two narrow religious exemptions. *Id.* § 5000A(d). A covered individual who fails to comply with the mandate is subject to a financial "penalty." *Id.* § 5000A(b)(1), (c). The penalty provision contains its own limited set of exemptions, *id.* § 5000A(e), but exemption from the penalty does not obviate the individual's obligation to comply with the mandate. The two are separate.

The mandate is designed not just to target individuals who consume health care services without paying for them, but also to "broaden the health insurance risk pool to include healthy individuals." ACA § 1501(a)(2)(G). Congress also intended the mandate to counteract the effects of costly insurance industry changes, most prominently, the "guaranteed issue" provision, which requires insurers to enroll every applicant for insurance, and the "preexisting conditions" change, which prohibits insurers from denying, canceling, capping, or increasing the cost of coverage based on an individual's preexisting health conditions or history. ACA § 1201. Those coverage mandates would have substantially increased the cost of insurance (and presumably would have been strenuously opposed by the insurance industry) absent the individual mandate's effect of forcing healthy individuals to purchase coverage they would otherwise not obtain. The mandate also forces numerous individuals who qualify for Medicaid under pre-existing law, but for whatever reason have previously declined to participate, to obtain coverage.

2. The Medicaid Expansions

Medicaid was originally designed in 1965 as a cooperative program that offered federal funding to States that voluntarily established health insurance plans for needy residents. Social Security Act of 1965, Title XIX, codified at 42 U.S.C. § 1396 *et seq.* At its inception, Medicaid covered approximately 4 million individuals and cost about $1 billion nationwide.[1] It has since expanded dramatically and is now the single largest federal grant-in-aid program to the States. Medicaid accounts for more than 40% of all federal funds dispersed to States—

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[1] John Klemm, Ph.D., Medicaid Spending: A Brief History, 22 Health Care Fin. Rev. 105, 106 (Fall 2000).

$251 billion in 2009 alone—and approximately 7% of federal spending.[2] In recent years, most States have received at least $1 billion in federal Medicaid funding, which covers at least half of each State's total Medicaid costs. 11th Cir. Record Excerpts ("R.E.") 1551–55.

The ACA substantially expands the eligibility and coverage thresholds that States must adopt to remain eligible to participate in Medicaid. Whereas States previously retained significant flexibility to determine who would be covered by Medicaid, the ACA requires States to cover all individuals with incomes up to 133% of the poverty level (with a 5% "income disregard" provision that effectively raises that number to 138%). ACA §§ 2001(a), 2002(a). Although the federal government will initially fund 100% of that expansion, by 2017, States will be responsible for 5% of those costs, with that number increasing to 10% by 2020. ACA § 2001(a)(3). Congress offered no increased funding to cover the millions of individuals who were previously eligible for Medicaid and opted not to enroll, but now must enroll to comply with the individual mandate. *Id.*

The Act also establishes a new "minimum essential coverage" level that States must provide to

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[2] The Long-Term Budget Outlook, June 2010, CBO, at 29-30, *available at* http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf; Budget of the United States Government: State-by-State Tables Fiscal Year 2010, *available at* http://www.gpoaccess.gov/usbudget/fy10/sheets/bis/8_3.xls; A Citizen's Guide to the Federal Budget—FY2002, http://www.gpoaccess.gov/usbudget/fy02/pdf/ guide.pdf at 9.

Medicaid recipients, eliminating flexibility States previously enjoyed to determine what level of coverage to provide. *Id.* § 2001(a)(2). And the Act locks States into maintaining formerly discretionary choices through its "maintenance of effort" provision, which requires that, "as a condition for receiving any Federal payments," a State "shall not have in effect eligibility standards, methodologies, or procedures ... that are more restrictive than ... [those] in effect on the date of enactment of the [ACA]" until the State has complied with other aspects of the ACA. *Id.* § 2001(b). The effect is to both eliminate discretion and essentially punish States for having voluntarily extended more generous coverage. Finally, the Act requires States not only to pay the costs of care and services, but also to assume responsibility for providing "the care and services themselves." ACA § 2304. In conjunction with these expansions, the federal government predicts that federal Medicaid spending will increase by $434 billion by 2020. R.E. 1425.

Unlike when it has amended Medicaid in the past, Congress did not tie its new conditions only to those additional federal funds made newly available under the ACA. It instead made the new terms a condition of continued participation in Medicaid, thereby threatening each State with the loss of all federal Medicaid funds—on average, more than a billion dollars per year—unless it adopts the Act's substantial expansions of state obligations.

3. The Employer Mandates

The Act treats States like any other employer in imposing a collection of employer mandates designed to compel expansion of employer-sponsored insurance. ACA §§ 1511–15. Under those provisions, a State must provide every employee working 30 or more hours a week with a federally mandated level of insurance, or face substantial penalties. No accommodation is made for the unique sovereign status of the States.

B. The District Court Proceedings

Shortly after Congress passed the ACA, Florida and 12 other States brought this action seeking a declaration that the Act is unconstitutional. They have since been joined by 13 additional States, the National Federation of Independent Business ("NFIB"), and individuals Kaj Ahlburg and Mary Brown. The States argued that, *inter alia*, the individual mandate exceeds Congress's enumerated powers, the Medicaid expansions are unconstitutionally coercive, and the employer mandates impermissibly interfere with state sovereignty. The States maintained the entire Act must be invalidated because its central unconstitutional provisions cannot be severed.

The District Court dismissed the States' challenge to the employer mandates, holding it foreclosed by *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985). Pet.App.463. The parties then filed cross-motions for summary judgment on the individual mandate and Medicaid challenges.

The District Court granted summary judgment to the federal government on the Medicaid expansions and in favor of the States on the individual mandate. As to Medicaid, the court found existing precedent insufficient to support invalidation of spending legislation as unconstitutionally coercive. Pet.App.315. Although the court acknowledged "the difficult situation in which the states find themselves," it concluded that "unless and until" this Court "revisit[s] and reconsider[s] its Spending Clause cases," "the states have little recourse to remaining the very junior partner in th[e state-federal] partnership." Pet.App.315.

As to the individual mandate, the District Court concluded that the Commerce Clause does not grant Congress power to "penalize a passive individual for failing to engage in commerce." Pet.App.354. The court also concluded that the mandate could not be justified under the Necessary and Proper Clause because it undermines "'essential attributes' of the Commerce Clause limitations on the federal government's power." Pet.App.381. The court also rejected the argument that the mandate is a valid exercise of Congress's taxing power, concluding that the penalty attached to the mandate is not a tax. Pet.App.189.

Finally, the District Court concluded that the individual mandate is not severable from the rest of the Act. The court first noted the federal government's concession that "the individual mandate and the Act's health insurance reforms ... will rise or fall together," which it found "extremely significant because the various insurance provisions, in turn, are the very heart of the Act itself." Pet.App.382, 388. Examining the interplay between the mandate, the insurance changes, and the rest of the Act, the court concluded that "[i]t would be impossible to ascertain on a section-by-section basis if any particular statutory provision could stand (and was intended by Congress to stand) independently of the individual mandate," and that any attempt to do so would "be tantamount to rewriting a statute in an attempt to salvage it." Pet.App.394.

C. The Eleventh Circuit's Decision

The Eleventh Circuit affirmed the District Court's holdings as to the Medicaid expansions and the individual mandate, but reversed the court's severance holding. Pet.App.3.

1. "[N]ot without serious thought and some hesitation," the Eleventh Circuit rejected the States' coercion challenge to the Medicaid expansions. Pet.App.66. The court recognized that "many circuits [have] conclu[ded] that the [coercion] doctrine, twice recognized by the Supreme Court, is not a viable defense to Spending Clause legislation," and that "[e]ven in those circuits that do recognize the coercion doctrine, it has had little success." Pet.App.62–63. But the court concluded that "[t]o say the coercion doctrine is not viable or does not exist," as some circuits have, "is to ignore Supreme Court precedent." Pet.App.65. It further noted, "[i]f the government is correct that Congress *should* be able to place any and all conditions it wants on the money it gives to the states, then the Supreme Court must be the one to say it." Pet.App.65–66.

The court considered five factors relevant to analysis of the States' claim: (1) "Congress reserved the right to make changes to the [Medicaid] program"; (2) "the federal government will bear nearly all of the costs associated with the expansion"; (3) "states have plenty of notice ... to decide whether they will continue to participate in Medicaid"; (4) "states have the power to tax and raise revenue, and therefore can create and fund programs of their own if they do not like Congress's terms"; and (5) the Secretary of Health and Human Services has "discretion to withhold all or merely a portion of funding from a noncompliant state." Pet.App.66–69. The court found those factors, "[t]aken together," sufficient to defeat the States' claim. Pet.App.69.

2. The Eleventh Circuit held the individual mandate unconstitutional. In a joint opinion by Chief Judge Dubina and Judge Hull, the court concluded that "[t]he federal government's assertion of power, under the Commerce Clause, to issue an economic mandate for Americans to purchase insurance from a private company for the entire duration of their lives is unprecedented, lacks cognizable limits, and imperils our federalist structure." Pet.App.171.

The court rejected the theory that "because Americans have money to spend and must inevitably make decisions on where to spend it, the Commerce Clause gives Congress the power to direct and compel an individual's spending in order to further its overarching regulatory goals." Pet.App.113. The court observed that "Congress has never before exercised this supposed authority," and that "th[is] Court has never ... interpret[ed] the Commerce Clause to allow Congress to dictate the financial decisions of Americans through an economic mandate." Pet.App.115,116.

The Eleventh Circuit also rejected the federal government's attempt to justify the mandate by aggregating each individual's decision not to purchase health insurance to produce a substantial effect on commerce. The court found that theory "limitless," observing that, "[g]iven the economic reality of our national marketplace, any person's decision not to purchase a good would, when aggregated, substantially affect interstate commerce." Pet.App.124. The court concluded that "the government's struggle to articulate cognizable, judicially administrable limiting principles only reiterates the conclusion we reach today: there are none." Pet.App.137. The court also concluded that the mandate could not be justified as essential to a larger regulatory scheme, noting that this Court has never employed that reasoning to sustain a federal regulation "where plaintiffs contend that the entire class of activity is outside the reach of congressional power." Pet.App.160.

Finally, the court concluded that the mandate cannot be sustained as an exercise of Congress's taxing power because the mandate "is a civil regulatory penalty and not a tax." Pet.App.188.

3. The Eleventh Circuit reached precisely the opposite conclusion as the District Court on severability: it deemed the mandate entirely severable from the Act; not a single provision beyond the mandate was invalidated. As to the bulk of the Act—including the Medicaid expansions and employer mandates—the Eleventh Circuit found it sufficient that "[e]xcising the individual mandate ... does not prevent the remaining provisions from being 'fully operative as a law.'" Pet.App.191.

Examining the guaranteed issue and preexisting conditions provisions in more detail, the court rejected Congress's finding that the mandate is essential to those provisions and the federal government's concession that they cannot be severed from the mandate. Concluding that "multiple features ... weaken the mandate's practical influence on the two insurance product reforms," the court deemed the interrelatedness of those provisions insufficient to warrant non-severability, "particularly ... because the reforms of the health insurance help consumers who need it the most." Pet.App.201,203–204.

4. Judge Marcus concurred in the majority's rejection of the States' coercion claim and its conclusion that the individual mandate cannot be sustained under Congress's taxing power, but dissented from its holding that the mandate exceeds Congress's powers under the Commerce and Necessary and Proper Clauses.

REASONS FOR GRANTING THE PETITION

The ACA effects a dramatic expansion of federal authority that destroys the "healthy balance of power between the States and the Federal Government." *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991). This Court should grant plenary review to restore that essential balance. This case, and this case alone, provides a vehicle to address all the major objections to the Act's reworking of Our Federalism, and to do so in the context of an extraordinary challenge to federal overreaching brought by over half the Nation's States.

First, the Court should grant certiorari to confirm that all the other limits on Congress's enumerated powers—and the very process of enumeration itself—are not rendered nugatory by a limitless spending power. The Court has long recognized that a federal financial inducement can be so massive as to leave States with no choice but to accept it, no matter how destructive to their sovereignty the attached conditions may be. This case presents an ideal opportunity to reaffirm that principle, which has been largely ignored and even expressly rejected by multiple courts of appeals. By conditioning *all* of the States' federal Medicaid funding—for most States, more than a billion dollars each year—upon agreement to substantially expand their Medicaid programs, the ACA passes the point at which pressure turns into compulsion and achieves forbidden direct regulation of the States.

Simply put, if that does not cross the line into improper coercion, then no statute ever will. The amounts at issue are staggering, the conditions attach to pre-existing pots of funding, not just new money, and the Act locks States into previously voluntary choices. The Court should grant plenary review to reaffirm that such a coercive exercise of Congress's spending power is neither necessary nor proper and violates the Tenth Amendment and fundamental federalism principles inherent in the Constitution.

Second, this Court should grant certiorari to consider whether Congress may treat States no differently from any other employer for purposes of the employer mandates without running afoul of the Constitution's fundamental structural limits. While the Court in *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985), abandoned any judicial effort to impose such limits, subsequent cases have demonstrated a revitalized effort by this Court to enforce the Constitution's structural guarantees of federalism. The dissenting Justices in *Garcia* predicted that the decision would not stand the test of time, and subsequent developments have demonstrated the wisdom of that prediction. Only this Court can reconsider *Garcia*, and it should grant plenary review to do so here.

Third, the Court should grant certiorari to examine the Eleventh Circuit's erroneous severability determination. Four courts have struck down the individual mandate, and each has reached a different conclusion as to how much of the balance of the Act should remain in place. Given the fundamental reordering of the health care market worked by the ACA, the extent to which the Act survives is every bit as practically, if not doctrinally, important as whether the mandate is constitutional. Lower courts have divided on both questions. This Court should grant certiorari in a case that provides the Court with the best opportunity to consider both the constitutionality of the mandate and the severability question that arises if the mandate and/or the Medicaid provisions are struck down. The decision below is the only Court of Appeals decision to reach the severability question and is thus an ideal vehicle to address it. It is also a particularly appropriate candidate for this Court's review because the Eleventh Circuit's severability analysis is inconsistent with this Court's precedents. The court's decision erroneously leaves the entire Act in place—

even provisions that the federal government concedes cannot be divorced from the mandate—notwithstanding compelling evidence that Congress intended the mandate to function as the Act's essential lynchpin and would never have passed the Act without it. The Court should grant plenary review.

I. The Court Should Grant Review To Determine Whether Core Provisions of the ACA Violate the Tenth Amendment and the Broader Federalism Principles That the Amendment Reflects.

A. The Court Should Resolve Whether the ACA's Expansions to Medicaid Are Unconstitutionally Coercive.

The decision below cannot be reconciled with this Court's precedent concerning the scope of Congress's spending power. Indeed, the Eleventh Circuit's decision threatens to render for naught all of this Court's efforts to put outer limits on Congress's enumerated powers. If Congress can condition federal mandates on the continued availability of vast sums of taxpayer money that States previously accepted based on an earlier set of conditions, then anything that Congress is denied the power to do directly can be accomplished indirectly via the spending power. That cannot be correct.

"[T]he federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for [courts] to admit inability to intervene when one or the other level of Government has tipped the scales too far." *United States v.*

Lopez, 514 U.S. 549, 578 (1995) (Kennedy, J., concurring). Courts surely have the ability to intervene when the federal government threatens States with the loss of billions in federal funding unless they capitulate to its demands. The Eleventh Circuit's conclusion to the contrary not only is incorrect, but exemplifies the lower courts' confusion concerning—if not outright nullification of—this Court's spending power jurisprudence. This Court should grant plenary review to consider the States' spending power challenge.

1. Courts Are Deeply Divided Over Whether and How to Apply the Coercion Doctrine.

"No matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the States to regulate." *New York v. United States*, 505 U.S. 144, 178 (1992). There is no exception to that general rule for legislation that depends on Congress's spending power, and so this Court has long "recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion,'" *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (quoting *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937)), "in contravention of the Tenth Amendment or of restrictions implicit in our federal form of government." *Steward Machine*, 301 U.S. at 585; *see also United States v. Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring) ("The limits on the spending power have not been much discussed, but if the relevant standard is parallel to the Commerce Clause cases, then the limits and the analytical approach in those precedents should be respected."). That line between pressure and compulsion ensures that whether to accept federal funds and the conditions that come with them "remains the prerogative of the States not merely in theory, but in fact." *Dole*, 483 U.S. at 211–12.

"To say that the coercion doctrine is not viable or does not exist is to ignore Supreme Court precedent." Pet.App.65; *see also Va. Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997) (en banc) (plurality opinion) ("if th[is] Court meant what it said in *Dole*, then ... a Tenth Amendment claim of the highest order lies where" Congress exercises its spending power coercively). Yet that is precisely what multiple courts of appeals have done, reasoning that "courts are not suited to evaluating whether the states are faced ... with an offer they cannot refuse or merely a hard choice." *Oklahoma v. Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981); *see also N.H. Dep't of Emp't Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980). Although the first courts to do so reached that conclusion before *Dole*, that has not prevented other courts from following their lead even after *Dole* reaffirmed the coercion doctrine's vitality. *See, e.g.*, *Nevada v. Skinner*, 884 F.2d 445, 448–49 (9th Cir. 1989) (coercion doctrine presents "questions of policy and politics that range beyond [the judiciary's] normal expertise" and should be discarded because States are "adequately protected by the national political process"); *Kansas v. United States*, 214 F.3d 1196, 1202 (10th Cir. 2000) (declaring doctrine "unclear" and "suspect").

Although other courts have been more reluctant to reject openly a doctrine that this Court continues to recognize, their cursory disposal of strong coercion claims leaves little room for doubt that such claims will never prevail in their courts. *See, e.g.*, *Pace v. Bogalusa City Sch. Bd.*, 403 F.3d 272, 287 (5th Cir. 2005) (en banc) (threatened loss of $800 million non-coercive because State could have "declin[ed] federal funds"); *A.W. v. Jersey City Pub. Sch.*, 341 F.3d 234, 255 (3d Cir. 2003) ("state's powers as a political sovereign, especially its authority to tax, appear more than capable of preventing undue coercion"); *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000) (en banc) (threatened loss of $250 million "politically painful," not coercive); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (coercion "not reflected" by threatened loss of all Medicaid funding).

By contrast, the Fourth Circuit not only has refused to discard this Court's precedent, but has proved the coercion doctrine capable of meaningful application. *See Riley*, 106 F.3d at 569 (withholding $60 million education grant based on State's failure to comply with single condition would be unconstitutionally coercive). As Judge Luttig's plurality opinion for the en banc court in *Riley* explained, the coercion doctrine provides a critical check on Congress's power to "impose its policy preferences upon the States by placing conditions upon the return of revenues that were collected from the States' citizenry in the first place." *Id.* at 570. Accordingly, when Congress "withholds the entirety of a substantial federal grant" from States that refuse to "submit to the policy dictates of Washington in a matter peculiarly within their powers as sovereign States," then "a Tenth Amendment claim of the highest order lies." *Id.*

The Fourth Circuit is not alone in continuing to recognizing the vital role the coercion doctrine plays. Although the Eleventh Circuit erred in its application of the doctrine to the States' claim, *see infra* Part I.A.2, it agreed that "Congress cannot ... threaten the loss of funds so great and important to the state's integral function ... as to compel the state to participate in the 'optional' legislation." Pet.App.66. Moreover, four judges on the en banc Eighth Circuit would have applied the coercion doctrine to hold the threatened loss of $250 million in education funding unconstitutional. *See Jim C.*, 235 F.3d at 1083 (Bowman, J., dissenting) ("proportion of federal funds ... placed at risk ... (100%), the amount of those funds (some $250,000,000), and the difficulty of making up for th[at] loss ... all lead to the conclusion that pressure has turned into compulsion"). And while six judges on the en banc Fifth Circuit found the threatened loss of $800 million in education funding insufficient to establish coercion "under the current state of the law," they raised the compelling question, "[i]f not now, and on this showing, when, and on what showing will federal grants be deemed unconstitutionally coercive?" *Pace*, 403 F.3d at 300 n.2 (Jones, J., concurring in part and dissenting in part). This case provides an ideal opportunity for this Court to reaffirm that the coercion doctrine places real, not wholly theoretical, limits on Congress's spending power.

2. The Eleventh Circuit Erred in Rejecting the States' Compelling Coercion Claim.

By any measure, the States' coercion claim is one of the strongest ever presented. Medicaid is the single largest federal grant-in-aid program to the States. It accounts for more than 40% of *all* federal funds that States receive, and approximately 7% of all federal spending. The majority of States receive more than ***$1 billion*** in Medicaid funding each year—all raised from taxpayers—with that number only projected to increase under the ACA. States spend, on average, 20% of their budgets on Medicaid, and federal funds cover at least half (oftentimes more) of each State's costs. R.E. 1555. Although the precise impact of Medicaid funding differs from State to State, the loss of all Medicaid funding would be devastating to any State.

The ACA's expansions to Medicaid were expressly crafted to exploit the threat of that devastating loss by putting all of that funding—not just a distinct pot of newly available funds—on the line. In the past, when Congress sought to expand Medicaid coverage, it offered additional funding to States that agreed to additional obligations, without threatening existing funding of States that did not. *See, e.g.*, American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5001(f); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401(b). The ACA employs a dramatically different approach. Rather than offer increased funding to States willing and able to increase eligibility and coverage, Congress made the ACA's substantial expansions to Medicaid a mandatory condition of continued participation. The ACA essentially holds the States hostage based on their earlier decision to establish a Medicaid infrastructure and accept federal funds subject to different conditions. The ACA uses the States' decision to accept earlier federal inducements against them and, in doing so, presents States with no real choice: they must abandon completely the existing Medicaid system and funding or accept the radical new conditions. This amounts to a massive bait-and-switch.

As more than half of the States are here attesting, there is no plausible argument that a State could afford to turn down a federal inducement as massive as all Medicaid funding, particularly when doing so would mean taking on 100% of the burden of covering its neediest residents' medical costs, even though massive amounts of money would still be extracted from in-state taxpayers to fund Medicaid in the other 49 States. The latter point is critical. It might be acceptable for this Court to abandon any effort to police limits on the spending power if the money used to induce the States to "accept" conditions were coming from some place other than taxpayers. But there is no such pot of money. Because the Medicaid funds used to induce the States come from their own taxpayers, the "option" of declining federal funds and paying for medical care for the indigent through new taxes on in-state taxpayers already funding that care in the other 49 States is illusory.

Tellingly, the ACA itself recognizes that the States have no meaningful choice but to accept the new conditions and continue to participate in

Medicaid: the Act mandates that millions of individuals covered by Medicaid must obtain insurance coverage, yet it provides no alternative to Medicaid. Even the federal government has not attempted to argue that the States have any real choice in the matter. It has instead simply insisted that spending legislation can *never* be coercive, no matter how much money is on the table. *See* Pet.App.65–66 (noting government's argument that "Congress *should* be able to place any and all conditions it wants on the money it gives to the states").

The Eleventh Circuit acknowledged the merit of the States' argument but, "not without serious thought and some hesitation," Pet.App.66, rejected it. The Eleventh Circuit's reasoning was erroneous and confirms the need for this Court's review. For example, the court stressed that the States "have plenty of notice ... to decide whether they will continue to participate in Medicaid." Pet.App.68. But notice of a coercive choice does not make it less coercive. And, of course, when the States originally accepted Medicaid funds subject to certain conditions, they did not have notice that their participation in the program and development of the necessary infrastructure would be used by Congress to hold them hostage to later demands.

The Eleventh Circuit's analysis also gives short shrift to the enormous amount of federal funds—raised from taxpayers in the States—tied to the ACA's new conditions. To illustrate, Florida devotes approximately 26% of its entire state budget to Medicaid and received *$8 billion* in federal Medicaid funding in 2008. To maintain existing, pre-ACA benefits without federal funding, Florida would have to devote more than *60%* of all state tax revenues to Medicaid. R.E. 493. To do so without eliminating more than a third of existing spending, Florida would need its residents to pay *billions* more in taxes, while Florida would at the same time "be deprived of the benefits of a return ... of the federal tax monies collected from" those same residents to fund Medicaid. *Jim C.*, 235 F.3d at 1083 (Bowman, J., dissenting). If that implausible "alternative" is sufficient to render a State's continued participation in Medicaid voluntary "not merely in theory, but in fact," then the coercion doctrine itself is "more rhetoric than fact." *Dole*, 483 U.S. at 211–12.

The Eleventh Circuit also found it significant that "Congress reserved the right to make changes to the [Medicaid] program." Pet.App.66. But the States are not arguing that Congress may not make changes to Medicaid. They are arguing that Congress may not *force* changes upon the States by threatening them with the loss of billions of federal dollars. The court also deemed it relevant that the federal government will initially "bear nearly all of the costs associated with the expansion." Pet.App.67. But "the coercion inquiry focuses on the financial inducement offered by Congress," *Madison v. Virginia*, 474 F.3d 118, 128 (4th Cir. 2006), not on the amount of money a State is "being coerced into spending." Pet.App.68. The very purpose of the doctrine is to protect the *State*'s prerogative to determine whether the inducement Congress has offered is worth the costs that come with it.

Finally, there is no merit to the Eleventh Circuit's attempt to sidestep the issue by claiming that States do *not* risk all Medicaid funding by rejecting the ACA's terms. *See* Pet.App.68–69. That a State must comply with the ACA or opt out of Medicaid has been an undisputed fact throughout this litigation. As the federal government explained from the outset, "the mandatory coverage of groups that Congress has designated as 'categorically needy' is and always has been *the* core requirement of Medicaid. ... States retain[] discretion to expand *but not contract* the coverage. *The Act does not change those central features.*" Govt.'s Dist. Ct. Mot. to Dismiss Mem. 16 (some emphasis added); *see also* Govt.'s 11th Cir. Resp./Reply Br. 54 (ACA expansions "relate to the very contours of the program itself—the basic eligibility requirements"). That understanding is confirmed by the Act, which amends the Medicaid statute to provide that a State "*must* [cover] ... all individuals ... whose income ... does not exceed 133 percent of the poverty line." 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (emphasis added) (ACA § 2001(a)(1)(C)); *see also* ACA § 2001(b) (rendering compliance with maintenance-of-effort provision "a condition for receiving *any Federal payments*" (emphasis added)).

It is not remotely plausible that Congress left open the kind of gaping hole the Eleventh Circuit contemplated in one of the ACA's central mechanisms for imposing "near-universal" health insurance coverage. ACA § 1501(a)(2)(D). The statute the court cited does not support that untenable conclusion: it grants the Secretary discretion to continue funding "parts of [a State's] plan not affected" by a State's noncompliance with discrete provisions, not to continue funding a plan that fails to comply with core program requirements. *See* 42 U.S.C. § 1396c.

In sum, there is no dispute that the ACA threatens States with the loss of literally ***billions*** of dollars of federal funding ***each year*** if they do not capitulate to Congress' demand to significantly expand their Medicaid programs. As the 26 States that have joined forces to bring this petition have attested, Congress has left States with no choice but to accept its new conditions. "[T]he Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress's instructions." ***New York***, 505 U.S. at 162. Because that is precisely what the ACA's coercive tactics would achieve, the Court should grant certiorari and hold the Medicaid expansions unconstitutional.

B. The Court Should Resolve Whether the ACA's Employer Mandate Provisions Are Constitutional as Applied to the States.

The ACA requires each State to provide all full-time employees with a federally mandated level of health insurance and imposes harsh penalties on any State that fails to do so. In this regard, States are treated no differently from any other employer. Those provisions dramatically interfere with state sovereignty and violate the Tenth Amendment.

The District Court held the States' challenge to the employer mandate provisions foreclosed by *Garcia*. *Garcia* overruled *National League of Cities v. Usery*, 426 U.S. 833 (1976), and held that Congress may subject States to generally applicable employer regulations even when those regulations interfere with essential attributes of state sovereignty. *Garcia*, 469 U.S. at 531. The *Garcia* Court reached that conclusion based on reasoning that is very difficult to square with subsequent developments in this Court's enumerated powers and Tenth and Eleventh Amendment jurisprudence. Contrary to numerous more recent decisions recognizing the critically important judicial role in enforcing the Constitution's structural provisions, *Garcia* assumed that structural aspects of federalism could be enforced only through the political process. *See id.* at 554 ("the fundamental limitation that the constitutional scheme imposes on the Commerce Clause to protect the 'States as States' is one of process, rather than one of result").

In a dissent joined by Chief Justice Burger, then-Justice Rehnquist and Justice O'Connor, Justice Powell correctly charged the majority in *Garcia* with "substantially alter[ing] the federal system embodied in the Constitution." *Id.* at 557. His dissent admonished that "[t]he States' role in our system of governance is a matter of constitutional law, not of legislative grace," and emphasized that "the Tenth Amendment was adopted specifically to ensure that the important role promised the States by the proponents of the Constitution was realized." *Id.* at 567–68. The dissent also noted the majority's departure from the "many cases in which the Court has recognized not only the role, but also the importance, of state sovereignty." *Id.* at 574. In a separate dissent, Justice O'Connor concluded that the majority's opinion "provide[d] scant comfort to those who believe our federal system requires something more than a unitary, centralized government," but joined Justice Rehnquist in predicting that "this Court will, in time, again assume its constitutional responsibility." *Id.* at 589.

As Justices Rehnquist and O'Connor predicted, the animating reasoning of *Garcia* has since been largely rejected by this Court. In stark contrast to *Garcia*'s political-process-oriented view of the Constitution's structural limitations, more recent decisions have confirmed that the Tenth and Eleventh Amendments and the protections they embody impose real, judicially enforceable limits on Congress's ability to interfere with state sovereignty. *See, e.g.*, *New York*, 505 U.S. at 177 (striking down federal law as unconstitutional incursion on state sovereignty); *Printz v. United States*, 521 U.S. 898, 935 (1997) (same); *see also Bd. of Tr. of Univ. of Ala. v. Garrett*, 531 U.S. 356, 374 (2001) (rejecting effort to treat States like other employers for purposes of the Americans with Disabilities Act). As Justice Kennedy observed in his *Lopez* concurrence, the temptation for the political process to yield to "momentary political convenience" is too strong, and federalism "is too essential a part of our constitutional structure and plays too vital a role in securing freedom for [the Court] to admit inability to intervene." 514 U.S. at 578. It has been over 25 years since the *Garcia* dissenters predicted that the Court would need to reconsider this issue and resume "its constitutional responsibility." 469 U.S. at 589. Numerous doctrinal developments in the intervening quarter-century make clear that *Garcia*, not *National League of Cities*, is the jurisprudential outlier. Only this Court can reconsider *Garcia*. This Court should grant plenary review to do so.

II. The Court Should Grant Plenary Review to Consider the Severability of the Individual Mandate in Conjunction with the Question of the Mandate's Constitutionality.

Four courts have struck down the individual mandate as exceeding Congress's enumerated powers, and each has come to a different conclusion as to the consequences for the balance of the ACA. That severability question is of enormous practical importance. The Act's myriad provisions are universal in scope, imposing new obligations on everyone from the States to private employers to insurance companies to individuals. Some provisions have already taken effect, and many others require significant steps to be taken immediately to make compliance possible by the impending effective dates. States in particular must shoulder enormous burdens to comply with provisions of the Act that would not survive a proper severability analysis. This is an ideal case in which to consider both the severability question and the antecedent questions whether the mandates and the Medicaid changes are constitutional. This Court should grant certiorari to resolve which, if any, of the Act's hundreds of provisions will stand if those provisions fall.

A. The Severability Question Has Produced Widely Varying Results.

The four courts that have addressed whether the individual mandate is severable from rest of the ACA have purported to apply the same "well established" standard for severability. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (unconstitutional provision may be severed "[u]nless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not"). Yet each court has reached a different conclusion. As is clear from those opinions, how the severability analysis applies in these unusual circumstances is a complex question that warrants this Court's full consideration and definitive resolution.

In the first opinion to invalidate the individual mandate and address severability, the District Court "sever[ed] only section 1501 [of the ACA] and directly-dependent provisions which make specific reference to [it]." *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 790 (E.D. Va. 2010). The court did not base that conclusion on a finding that Congress would "have enacted those provisions which are within its power, independently of that which is not," or that the remaining provisions are "fully operative as a law." *Brock*, 480 U.S. at 684. The court instead declared it "virtually impossible with the present record to determine whether Congress would have passed" the ACA without the mandate, or "what, if any, portion of the bill would not be able to survive" without it. *Virginia*, 728 F. Supp. 2d at 789. The court then arbitrarily drew the line at provisions that "make specific reference to" the mandate, *id.* at 790, thereby leaving in place the Act's remaining core provisions.

The District Court in this case concluded that this Court's precedent required a very different result: it held the mandate non-severable and invalidated the entire Act. Pet.App.396–97. Although the court recognized "the *normal* rule ... that partial invalidation is proper," it found this case "anything but ... typical." Pet.App.383 (quotation marks omitted). After careful review of Congress's findings and the delicate fiscal balance the Act was designed to achieve, the court found it "reasonably 'evident' ... that the individual mandate was an essential and indispensable part of the health reform efforts," and that Congress did not intend the Act to survive without it. Pet.App.396.

The Eleventh Circuit concluded that this Court's precedent compelled precisely the opposite result: it severed *only* the mandate, and left the rest of the Act standing. Pet.App.205. Indeed, it did not even invalidate provisions that the federal government conceded must fall with the mandate. As to everything but the guaranteed issue and preexisting conditions provisions, the court found it sufficient that "[e]xcising the individual mandate ... does not prevent the remaining provisions from being 'fully operative as a law.'" Pet.App.191. The court engaged in no separate analysis of whether Congress "*would have* enacted those provisions ... independently of" the mandate. *Brock*, 480 U.S. at 684 (emphasis added). As to the guaranteed issue and preexisting conditions provisions, the court acknowledged Congress's express finding that "the individual mandate operates '*together with the other provisions of this Act*'" to achieve Congress's intended changes. Pet.App.203 n.142 (quoting 42 U.S.C. § 18091(a)(2)(C)). And it acknowledged the federal government's concession that these provisions could not be severed from the mandate.

Pet.App.204 n.144. But the court severed them anyway, concluding that Congress's assessment of the mandate's importance to the insurance provisions was erroneous, and that those changes are too important to fall because they "help consumers who need it the most." Pet.App.204.

Most recently, the District Court in *Goudy-Bachman v. U.S. Dep't of Health and Human Servs.*, —— F.Supp.2d ——, 2011 WL 4072875 (M.D. Penn. Sept. 13, 2011), took yet another approach: it found the mandate non-severable from the guaranteed issue and preexisting condition provisions, but left the rest of the Act intact. *Id.* at *21. Much like the District Court in *Virginia*, the court did not attempt to ascertain Congress's intent as to the bulk of the Act, positing that any effort to do so "would be a[n] immense undertaking, and ultimately speculative at best." *Id.* at *20. The court thus effectively limited its analysis to the two insurance provisions, which it concluded "rise[] and fall[] with" the mandate. *Id.* at *21.

As those four divergent opinions make clear, there is serious confusion as to how to apply this Court's severability jurisprudence to the ACA. That confusion stems in large part from the unusual facts at hand, including the extraordinary length and complexity of the Act and "the haste with which the final version of the 2,700 page bill was rushed to the floor for a Christmas Eve vote." *Virginia*, 728 F. Supp. 2d at 789. That lack of transparency makes it difficult to determine both to what extent the Act's several hundred provisions can function without the mandate, and whether Congress would have enacted even those provisions that on their face appear unrelated to the mandate without the delicate compromise of which the mandate was an essential part.

The disagreement among lower courts also evinces deeper uncertainty as to the state of severability law. Each court acknowledged compelling evidence that this is the rare instance in which "it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not." *Brock*, 480 U.S. at 684. Yet while the District Court in this case gave effect to Congress's evident intent, the courts in *Virginia* and *Goudy-Bachman* concluded that they were still required to leave the bulk of the Act intact, and the Eleventh Circuit concluded that nothing short of a non-severability clause could overcome the presumption of severability. Those conflicting conclusions reflect underlying confusion as to just how strong the presumption of severability is. This Court should grant certiorari and resolve this confusion.

B. This is an Ideal Vehicle for Review of the Severability Question and the Underlying Constitutional Challenge to the Mandate.

This case presents an ideal vehicle for addressing whether and to what extent the ACA and the challenged provisions can survive. This case alone allows the Court to resolve both of the major constitutional challenges to the statute—the spending clause and individual mandate issues—in a single case. This case alone allows this Court to address the severability question in a case where both lower courts have addressed that question. And this case alone allows the Court to do so in the context of 26 States who are already feeling the substantial financial impacts of the ACA's sweeping changes. The Court should grant review expeditiously to consider whether and to what extent "this massive and sweeping" legislation, Pet.App.206 n.145, is to remain the law of the land.

The individual mandate "represents a wholly novel and potentially unbounded assertion of congressional authority" with "far-reaching implications for our federalist structure." Pet.App.101, 205. It is now clear that the Courts of Appeals are deeply divided as to its constitutionality. One court upheld the mandate through a strained and misguided as-applied analysis, another rejected challenges to the mandate without reaching the merits, and the Court of Appeals here invalidated the mandate as exceeding Congress's power. *See Thomas More Law Ctr. v. Obama*, —— F.3d ——, 2011 WL 2556039, at *16 (June 29, 2011) (opinion of Sutton, J.); *Liberty Univ. v. Geithner*, —— F.3d ——, 2011 WL 3962915 (Sept. 8, 2011); Pet.App.2. All three decisions have generated separate opinions disagreeing with the majority's analysis. *See Thomas More*, 2011 WL 2556039, at *34 (Graham, J., sitting by designation, dissenting); *Liberty Univ.*, 2011 WL 3962915, at *22 (Davis, J., dissenting); Pet.App.208 (Marcus, J., dissenting). District courts have also continued to divide on the question. *Compare Virginia*, 728 F. Supp. 2d at 788 (mandate unconstitutional), Pet.App.300 (same), *and Goudy-Bachman*, 2011 WL 4072875, at *21 (same), *with Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d

882 (E.D. Mich. 2010) (mandate constitutional), *and Liberty Univ. v. Geithner*, 753 F.Supp.2d 611 (W.D. Va. 2010) (same). The deep division among the lower courts over whether an Act of Congress is constitutional is a question manifestly worthy of this Court's attention.

The challenges to the mandate and the Act as a whole also warrant resolution sooner rather than later. The mandate takes effect in 2014, meaning millions of individuals must already begin planning to afford the significant financial burden it will impose on them for the rest of their lives. The States are also struggling to figure out how to afford the substantial new costs—costs for which the ACA offers no increased federal funding and costs that manifestly give the States standing to object to the mandate—of extending Medicaid coverage to millions of currently eligible but unrolled individuals who will be forced to enroll to comply with the mandate.

Moreover, the mandate is the centerpiece of a "sweeping and comprehensive Act" that imposes a "large number and diverse array of new, or expanded, federally-funded programs, grants, studies, commissions, and councils." Pet.App.4, 24. Even as to provisions not yet in effect, the substantial costs of implementation are already being felt by States, private employers, and individuals. For example, Florida anticipates spending more than $5 million in FY2011 to begin implementing the ACA's Medicaid expansions. R.E. 574. And States must decide *now* whether to undertake the cumbersome process of creating "health benefit exchanges," as the federal government will preempt the process in any State that fails to make progress toward implementing exchanges by 2013. *See* ACA § 1321(c).

Because invalidation of the mandates and Medicaid provisions could result in invalidation of the entire Act—including already operative provisions—timely resolution of both the constitutional questions and the severance question is essential. And this is a particularly appropriate case in which to consider the severability question because the answer may well differ depending on whether the individual mandate alone is unconstitutional or whether the individual and employer mandates and Medicaid provisions all violate the Constitution. Addressing severability in a case with only the individual mandate at issue would be an artificial exercise.

Finally, this case provides a unique assurance that the Court can reach the merits of the individual mandate. The States believe that both the States—who must shoulder huge new financial burdens for currently eligible, but non-participating individuals who will be forced onto the Medicaid rolls by the individual mandate—and the individual petitioners and NFIB have standing to challenge the mandate. *Cf. Bond v. United States*, 131 S. Ct. 2355 (2011) (confirming individual standing to raise Tenth Amendment challenges without questioning States' standing). But some courts have questioned the standing of States and the ability of individual taxpayers to challenge the mandate. While neither objection is valid, a case involving both States and individuals as challengers offers the Court the best opportunity to ensure that it can resolve these critically important issues on the merits.[3] This Court can and should grant plenary review.

CONCLUSION

The Court should grant the petition.

Respectfully submitted,

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel

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[3] To the extent the Court wishes to consider whether the tax Anti-Injunction Act, 26 U.S.C. § 7421(a), affects the analysis, the arguably jurisdictional nature of that question would make it appropriate for separate briefing. Addressing that question here would maximize the chances of reaching the merits, both because the Act would not apply in this case if it is not jurisdictional, and because it likely would not reach the States anyway, as they are not taxpayers subject to the mandate. *See South Carolina v. Regan*, 465 U.S. 367 (1984); *cf. Raygor v. Regents of Univ. of Minn.*, 534 U.S. 533 (2002).

Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508

BILL COBB
Deputy Attorney General for
Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

September 27, 2011 *Counsel for Petitioners*

APPENDIX

NO. _____

In the

Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTAD, GOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITIONERS' APPENDIX — VOLUME I

SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

September 27, 2011 *(Additional Counsel Listed on Inside Cover)*

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Appendix A

IN THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

Nos. 11-11021 & 11-11067

Appeal from the United States District Court
for the Northern District of Florida
D.C. Docket No. 3:10-cv-00091-RV-EMT

STATE OF FLORIDA, by and through Attorney General, STATE OF SOUTH CAROLINA, by and through Attorney General, STATE OF NEBRASKA, by and through Attorney General, STATE OF TEXAS, by and through Attorney General, STATE OF UTAH, by and through Attorney General, et al.,

Plaintiffs – Appellees – Cross-Appellants,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF THE TREASURY, SECRETARY OF THE UNITED STATES DEPARTMENT OF TREASURY, UNITED STATES DEPARTMENT OF LABOR, SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR,

Defendants – Appellants – Cross-Appelles.

August 12, 2011

Before DUBINA, Chief Judge, and HULL and MARCUS, Circuit Judges.

DUBINA, Chief Judge, and HULL, Circuit Judge:[1]

Soon after Congress passed the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (2010) (the "Act"), the plaintiffs brought this action challenging the Act's constitutionality. The plaintiffs are 26 states, private individuals Mary Brown and Kaj Ahlburg, and the National Federation of Independent Business ("NFIB") (collectively the "plaintiffs").[2] The defendants are the federal Health and Human Services ("HHS"), Treasury, and Labor Departments and their Secretaries (collectively the "government").

The district court granted summary judgment (1) to the government on the state plaintiffs' claim that the Act's expansion of Medicaid is unconstitutional and (2) to the plaintiffs on their claim that the Act's individual mandate—that individuals purchase and continuously maintain health insurance from private companies[3]—is unconstitutional. The district court concluded that the individual mandate exceeded congressional authority under Article I of the Constitution because it was not enacted pursuant to Congress's tax power and it exceeded Congress's power under the Commerce Clause and the Necessary and Proper Clause. The district court also concluded that the individual mandate provision was not severable from the rest of the Act and declared the entire Act invalid.

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[1] This opinion was written jointly by Judges Dubina and Hull. *Cf. Waters v. Thomas*, 46 F.3d 1506, 1509 (11th Cir. 1995) (authored by Anderson and Carnes, J.J.) (citing *Peek v. Kemp*, 784 F.2d 1479 (11th Cir.) (en banc) (authored by Vance and Anderson, J.J.), *cert. denied*, 479 U.S. 939, 107 S. Ct. 421 (1986)).

[2] The 26 state plaintiffs are Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.

The government appeals the district court's ruling that the individual mandate is unconstitutional and its severability holding. The state plaintiffs cross-appeal the district court's ruling on their Medicaid expansion claim. For the reasons that follow, we affirm in part and reverse in part.[4]

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[3] As explained later, unless the person is covered by a government-funded health program, such as Medicare, Medicaid, and others, the mandate is to purchase insurance from a private insurer.

[4] We review the district court's grant of summary judgment *de novo*. *Sammy's of Mobile, Ltd. v. City of Mobile*, 140 F.3d 993, 995 (11th Cir. 1998). We review *de novo* a constitutional challenge to a statute. *United States v. Cunningham*, 607 F.3d 1264, 1266 (11th Cir.), *cert. denied*, 131 S. Ct. 482 (2010).

INTRODUCTION

Legal issues concerning the constitutionality of a legislative act present important but difficult questions for the courts. Here, that importance and difficulty are heightened because (1) the Act itself is 975 pages in the format published in the Public Laws;[5] (2) the district court, agreeing with the plaintiffs, held *all* of the Act was unconstitutional; and (3) on appeal, the government argues *all* of the Act is constitutional.

We, as all federal courts, must begin with a presumption of constitutionality, meaning that "we invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds." *United States v. Morrison*, 529 U.S. 598, 607, 120 S. Ct. 1740, 1748 (2000).

As an initial matter, to know whether a legislative act is constitutional requires knowing what is in the Act. Accordingly, our task is to figure out what this sweeping and comprehensive Act actually says and does. To do that, we outline the congressional findings that identify the problems the Act addresses, and the Act's legislative response and overall structure, encompassing nine Titles and hundreds of laws on a diverse array of subjects. Next, we set forth in greater depth the contents of the Act's five components most relevant to this appeal: the insurance industry reforms, the new state-run Exchanges, the individual mandate, the employer penalties, and the Medicaid expansion.

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[5] Pub. L. No. 111-148, 124 Stat. 119 (2010), Pub. L. No. 111-152, 124 Stat. 1029 (2010). Some of the sections of the Act have not yet been codified in the U.S. Code, and for those sections we cite to the future U.S. Code provision, along with the effective date if applicable.

After that, we analyze the constitutionality of the Medicaid expansion and explain why we conclude that the Act's Medicaid expansion is constitutional.

We then review the Supreme Court's decisions on Congress's commerce power, discuss the individual mandate—which requires Americans to purchase an expensive product from a private insurance company from birth to death—and explicate how Congress exceeded its commerce power in enacting its individual mandate. We next outline why Congress's tax power does not provide an alternative constitutional basis for upholding this unprecedented individual mandate. Lastly, because of the Supreme Court's strong presumption of severability and as a matter of judicial restraint, we conclude that the individual mandate is severable from the remainder of the Act. Our opinion is organized as follows:

I. STANDING

II. THE ACT

- A. Congressional Findings
- B. Overall Structure of Nine Titles
- C. Terms and Definitions
- D. Health Insurance Reforms
- E. Health Benefit Exchanges
- F. Individual Mandate

- G. Employer Penalty
- H. Medicaid Expansion

III. CONSTITUTIONALITY OF MEDICAID EXPANSION

- A. History of the Medicaid Program
- B. Congress's Power under the Spending Clause

IV. SUPREME COURT'S COMMERCE CLAUSE DECISIONS

V. CONSTITUTIONALITY OF INDIVIDUAL MANDATE UNDER THE COMMERCE POWER

- A. First Principles
- B. Dichotomies and Nomenclature
- C. Unprecedented Nature of the Individual Mandate
- D. *Wickard* and Aggregation
- E. Broad Scope of Congress's Regulation
- F. Government's Proposed Limiting Principles
- G. Congressional Findings
- H. Areas of Traditional State Concern
- I. Essential to a Larger Regulatory Scheme
- J. Conclusion

VI. CONSTITUTIONALITY OF INDIVIDUAL MANDATE UNDER THE TAX POWER

- A. Repeated Use of the Term "Penalty" in the Individual Mandate

B. Designation of Numerous Other Provisions in the Act as "Taxes"

C. Legislative History of the Individual Mandate

VII. SEVERABILITY

I. STANDING

As a threshold matter, we consider the government's challenge to the plaintiffs' standing to bring this lawsuit. "Article III of the Constitution limits the jurisdiction of federal courts to 'cases' and 'controversies.'" *Socialist Workers Party v. Leahy*, 145 F.3d 1240, 1244 (11th Cir. 1998) (citations omitted). As we have explained:

> The case-or-controversy constraint, in turn, imposes a dual limitation on federal courts commonly referred to as "justiciability." Basically, justiciability doctrine seeks to prevent the federal courts from encroaching on the powers of the other branches of government and to ensure that the courts consider only those matters that are presented in an adversarial context. Because the judiciary is unelected and unrepresentative, the Article III case-or-controversy limitation, as embodied in justiciability doctrine, presents an important restriction on the power of the federal courts.

Id. (citations omitted). Indeed, there are "three strands of justiciability doctrine—standing, ripeness, and mootness—that go to the heart of the Article III case or controversy requirement." *Harrell v. The Fla. Bar*, 608 F.3d 1241, 1247 (11th Cir. 2010) (quotation marks and alterations omitted).

As for the first strand, "[i]t is by now axiomatic that a plaintiff must have standing to invoke the jurisdiction of the federal courts." *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1266 (11th Cir. 2006). "In essence the question of standing is whether the litigant is entitled to have the court decide the merits of the dispute or of particular issues." *Primera Iglesia Bautista Hispana of Boca Raton, Inc. v. Broward Cnty.*, 450 F.3d 1295, 1304 (11th Cir. 2006) (quotation marks omitted). To demonstrate standing, a plaintiff must show that "(1) he has suffered, or imminently will suffer, an injury-in-fact; (2) the injury is fairly traceable to [the statute]; and (3) a favorable judgment is likely to redress the injury." *Harrell*, 608 F.3d at 1253; *see also Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61, 112 S. Ct. 2130, 2136 (1992). "The plaintiff bears the burden of establishing each of these elements." *Elend v. Basham*, 471 F.3d 1199, 1206 (11th Cir. 2006). And standing must be established for each claim a plaintiff raises. *See Harrell*, 608 F.3d at 1253–54. "We review standing determinations *de novo*." *Bochese v. Town of Ponce Inlet*, 405 F.3d 964, 975 (11th Cir. 2005).

In fact, "[s]tanding is a threshold jurisdictional question which must be addressed prior to and independent of the merits of a party's claims." *Id.* at 974 (quotation marks and alteration omitted). And "we are obliged to consider questions of standing regardless of whether the parties have raised them." *Id.* at 975.

Notably, the government does not contest the standing of the individual plaintiffs or of the NFIB to challenge the individual mandate. In fact, the government expressly concedes that one of the individual plaintiffs—Mary Brown—has standing to challenge the individual mandate. *See* Government's Opening Br. at 6 n.1 ("Defendants do not dispute that plaintiff Brown's challenge to the minimum coverage provision is justiciable."). Nor does the government dispute the state plaintiffs' standing to challenge the Medicaid provisions.

The only question raised by the government is whether the state plaintiffs have standing to challenge the individual mandate. The government claims that the state plaintiffs do not have standing because they are impermissibly suing the government as *parens patriae*—or as representatives of their citizens—in violation of the rule articulated in *Massachusetts v. Mellon*, 262 U.S. 447, 485–86, 43 S. Ct. 597, 600 (1923).[6] The state plaintiffs respond that they are not in violation of the *Mellon* rule, but rather have standing to challenge the individual mandate for three independent reasons: first, because the increased enrollment in Medicaid spurred by the individual mandate will cost the states millions of dollars in additional Medicaid funding; second, because they are injured by other provisions of the Act—such as the Medicaid expansion—from which the individual mandate cannot be severed; and finally, because the individual mandate intrudes upon their sovereign interest in enacting and enforcing state statutes that shield their citizens from the requirement to purchase health insurance. States' Opening Br. at 67–69.

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[6] In *Mellon*, the Supreme Court held that states cannot sue the federal government in a representative capacity to protect their citizens from the operation of an allegedly unconstitutional federal law. 262 U.S. at 485–86, 43 S. Ct. at 600. This has come to be known as the *Mellon* rule.

Although the question of the state plaintiffs' standing to challenge the individual mandate is an interesting and difficult one, in the posture of this case, it is purely academic and one we need not confront today. The law is abundantly clear that so long as at least one plaintiff has standing to raise each claim—as is the case here—we need not address whether the remaining plaintiffs have standing. *See, e.g., Watt v. Energy Action Educ. Found.*, 454 U.S. 151, 160, 102 S. Ct. 205, 212 (1981) ("Because we find California has standing, we do not consider the standing of the other plaintiffs."); *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 264 & n.9, 97 S. Ct. 555, 562 & n.9 (1977) ("Because of the presence of this plaintiff, we need not consider whether the other individual and corporate plaintiffs have standing to maintain suit."); *ACLU of Fla., Inc. v. Miami-Dade Cnty. Sch. Bd.*, 557 F.3d 1177, 1195 (11th Cir. 2009) ("Because Balzli has standing to raise those claims, we need not decide whether either of the organizational plaintiffs also has standing to do so."); *Jackson v. Okaloosa Cnty.*, 21 F.3d 1531, 1536 (11th Cir. 1994) ("In order for this court to have jurisdiction over the claims before us, at least one named plaintiff must have standing for each of the claims."); *Mountain States Legal Found. v. Glickman*, 92 F.3d 1228, 1232 (D.C. Cir. 1996) ("For each claim, if constitutional and prudential standing can be shown for at least one plaintiff, we need not consider the standing of the other plaintiffs to raise that claim."). Because it is beyond dispute that at least one plaintiff has standing to raise each claim here—the individual plaintiffs and the NFIB have standing to challenge the individual mandate, and the state plaintiffs undeniably have standing to challenge the Medicaid provisions—this case is justiciable, and we are permitted, indeed we are obliged, to address the merits of each. Accordingly, we turn to the constitutionality of the Act.

II. THE ACT

A. Congressional Findings

The congressional findings for the Act, including those relating to the individual mandate, are contained in two pages, now codified in 42 U.S.C. § 18091(a)(1)–(3). Approximately 50 million people are uninsured.[7] The congressional findings focus on these uninsureds, health insurance, and health care. *Id.*

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[7] U.S. Census Bureau, P60-238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009* 23 tbl.8 (2010) ("*Census Report*"), *available at* http://www.census.gov/prod/2010pubs/p60-238.pdf. Although the congressional findings do not state the precise number of the uninsured, the parties use the 50 million figure, so we will too.

Copies of the Internet materials cited in this opinion are on file in the Clerk's Office. *See* 11th Cir. R. 36, I.O.P. 10.

1. The Uninsured and Cost-Shifting Problems

The congressional findings state that some individuals make "an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers." *Id.* § 18091(a)(2)(A). In its findings, Congress determined that the decision by the uninsured to forego insurance results in a cost-shifting scenario. *Id.* § 18091(a)(2)(F).

Congress's findings identify a multi-step process that starts with consumption of health care: (1) some uninsured persons consume health care; (2) some fail to pay the full costs; (3) in turn the unpaid costs of that health care—$43 billion in 2008—are shifted to and spread among medical providers; (4) thereafter medical providers, by imposing higher charges, spread and shift the unpaid costs to private insurance companies; (5) then private insurance companies raise premiums for health policies and shift and spread the unpaid costs to already-insured persons; and (6) consequently already-insured persons suffer higher premiums. *Id.* § 18091(a)(2). Also, some uninsured persons continue not to buy coverage because of higher premiums. *Id.*

The findings state that this cost-shifting scenario increases family premiums on average by $1,000 per year. *Id.* § 18091(a)(2)(F). Although not in the findings, the data show the cost-shifting increases individual premiums on average by $368–410 per year.[8] The cost-shifting represents roughly 8% of average premiums.[9]

In its findings, Congress also points out that national health care spending in 2009 was approximately $2.5 trillion, or 17.6% of the national economy.[10] *Id.* § 18091(a)(2)(B). Thus, the $43 billion in shifted costs represents about 1.7% of total health care expenditures. Of that $2.5 trillion in national health care spending in 2009, federal, state, and local governments paid $1.1 trillion, or 44%.[11]

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[8] Uncompensated care costs translate into "a surcharge of $368 for individual premiums and a surcharge of $1017 for family premiums in 2008." *See* Families USA, *Hidden Health Tax: Americans Pay a Premium* 7 (2009), *available at* http://familiesusa2.org/assets/pdfs/hiddenhealth-tax.pdf (cited by both the plaintiffs and the government).

[9] "[A] 'hidden tax' on health insurance accounts for roughly 8% of the average health insurance premium" and "[t]his cost-shift added, on average, $1,100 to each family premium in 2009 and about $410 to an individual premium." Br. of *Amici Curiae* Am. Ass'n of People with Disabilities, *et al.*, in Support of the Government at 15 (citing Ben Furnas & Peter Harbage, Ctr. for Am. Progress Action Fund, *The Cost Shift from the Uninsured* 1–2 (2009), *available at* http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf (calculations based on a 2005 analysis by Families USA)).

[10] *See* Centers for Medicare & Medicaid Services ("CMS"), *National Health Expenditure Web Tables* tbls.1, 5, 11, *available at* http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf (derived from calculations).

[11] *See* CMS, *National Health Expenditure Web Tables*, *supra* note 10, at tbl.5. The governments' health care spending in 2009 included $503 billion for Medicare and $374 billion for

Private insurers still paid for 32% of health care spending in 2009,[12] *id.*, through: (1) primarily private employer-based insurance plans, or (2) the private individual insurance market. The private *employer-based* health system covers 176 million Americans. *Id.* § 18091(a)(2)(D). The private *individual insurance market* covers 24.7 million people.[13] Undisputedly, "[h]ealth insurance and health care services are a significant part of the national economy." *Id.* § 18091(a)(2)(B).

2. $90 Billion Private Underwriting Costs Problem

Congress also recognized that many of the uninsured desire insurance but have been denied coverage or cannot afford it. Its findings emphasize the barriers created by private insurers' underwriting practices and related administrative costs. *Id.* § 18091(a)(2)(J). Private insurers want

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Medicaid and the Children's Health Insurance Program ("CHIP").

Projected Medicare spending is $723.1 billion in 2016 and $891.4 billion in 2019. CMS, *Nat'l Health Expenditure Projections 2009–2019* tbl.2, *available at* http://www.cms.gov/NationalHealthExpendData/Downloads/NHEProjections2009to2019.pdf.

With the Act's Medicaid expansion and other factors, projected Medicaid and CHIP spending is $737.5 billion in 2016 and $896.2 billion in 2019. *Id.*

[12] *See* CMS, *National Health Expenditure Web Tables*, *supra* note 10, at tbl.3 (derived from calculations).

[13] *See Census Report*, *supra* note 7, at 22–25 & 23 tbl.8 (derived from calculations).

healthy insureds and try to protect themselves against unhealthy entrants through medical underwriting, especially in the individual market. As a result of medical underwriting, many uninsured Americans—ranging from 9 million to 12.6 million—voluntarily sought health coverage in the individual market but were denied coverage, charged a higher premium, or offered only limited coverage that excludes a preexisting condition.[14]

In its findings, Congress determined that the "[a]dministrative costs for private health insurance" were $90 billion in 2006, comprising "26 to 30 percent of premiums in the current individual and small group markets." *Id.* The findings state that Congress seeks to create health insurance markets "that do not require underwriting and eliminate its associated administrative costs." *Id.* The Act requires private insurers to allow all applicants to enroll. 42 U.S.C. § 300gg-1(a). Congress stated that the Act, by eliminating underwriting costs, will lower health insurance premiums. *Id.*

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[14] HHS, *Coverage Denied: How the Current Health Insurance System Leaves Millions Behind*, http://www.healthreform.gov/reports/denied_coverage/index.html (citing Commonwealth Fund Biennial Health Insurance Survey, 2007); Sara R. Collins, *et al.*, *The Commonwealth Fund, Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief* xi (2011), *available at* http://www.commonwealthfund.org/~/media/Files/SuSurve/2011/1486_Collins_help_on_the_horizon_2010_biennial_survey_report_FINAL_31611.pdf.

3. Congress's Solutions

Given the 50 million uninsured, $43 billion in uncompensated costs, and $90 billion in underwriting costs, Congress determined these problems affect the national economy and interstate commerce. *Id.* § 18091(a)(2). The congressional findings identify what the Act regulates: (1) the "health insurance market," (2)"how and when health care is paid for," and (3) "when health insurance is purchased." *Id.* § 18091(a)(2)(A), (H). The findings also state that the Act's reforms will significantly reduce the number of the uninsured and will lower health insurance premiums. *Id.* § 18091(a)(2)(F).

To reduce the number of the uninsured, the Act employs five main tools: (1) comprehensive insurance industry reforms which alter private insurers' underwriting practices, guarantee issuance of coverage, overhaul their health insurance products, and restrict their premium pricing structure; (2) creation of state-run "Health Benefit Exchanges" as new marketplaces through which individuals, families, and small employers, now pooled together, can competitively purchase the new insurance products and obtain federal tax credits and subsidies to do so; (3) a mandate that individuals must purchase and continuously maintain health insurance or pay annual penalties; (4) penalties on private employers who do not offer at least some type of health plan to their employees; and (5) the expansion of Medicaid eligibility and subsidies.

The Act's Medicaid expansion alone will cover 9 million of the 50 million uninsured by 2014 and 16 million by 2016.[15] The Act's health insurance reforms remove private insurers' barriers to coverage and restrict their pricing to make coverage accessible to the 9 to 12 million uninsured who were denied coverage or had their preexisting conditions excluded.[16] The Act's new Exchanges, with significant federal tax credits and subsidies, are predicted to make insurance available to 9 million in 2014 and 22 million by 2016.[17]

Congress's findings state that the Act's multiple provisions, combined together:[18]

(1) "will add millions of new consumers to the health insurance market" and "will increase the number and share of Americans who are insured";

(2) will reduce the number of the uninsured, will broaden the health insurance risk pool to include additional healthy individuals, will increase economies of scale, and will significantly reduce

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[15] CBO's *Analysis of the Major Health Care Legislation Enacted in March 2010*: Before the Subcomm. on Health of the H. Comm. on Energy & Commerce 112th Cong. 18 tbl.3 (2011) (Statement of Douglas Elmendorf, Director, Cong. Budget Office) [hereinafter CBO, *Analysis*], *available at* http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCare Legislation.pdf.

[16] *See* HHS, *Coverage Denied*, and Collins, *supra* note 14.

[17] CBO, *Analysis*, *supra* note 15, at tbl.3.

[18] The congressional findings refer six times to the individual mandate "requirement, together with the other provisions of this Act." 42 U.S.C. § 18091(a)(2)(C), (E), (F), (G), (I), (J).

insurance companies' administrative costs, all of which will lower health insurance premiums;

(3) will build upon and strengthen the private employer-based health insurance system, which already covers "176,000,000 Americans"; and

(4) will achieve "near-universal" coverage of the uninsured.

Id. § 18091(a)(2).

Although the congressional findings summarily refer to "the uninsured," the parties' briefs and the 52 *amici* briefs contain, and indeed rely on, additional data about the uninsured. Before turning to the Act, we review that data.[19]

4. Data about the Uninsured and Uncompensated Care

So who are the uninsured? As to health care usage, the uninsured do not fall into a single category. Many of the uninsured do not seek health care each year. Of course, many do. In 2007, 57% of the 40 million uninsured that year used some medical services; in 2008, 56% of the 41 million uninsured that year used some medical services.[20]

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[19] There has been no evidentiary objection by any party to the data and studies cited in the parties' briefs or in any of the *amici* briefs. In fact, at times the parties cite the same data.

[20] HHS, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Household Component Summary Tables ("MEPS Summary Tables"), Table 1: Total Health Services–Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment:

As to medical services, 50% of uninsured people had routine checkups in the past two years; 68% of uninsured people had routine checkups in the past five years.[21] In 2008, the uninsured made more than 20 million visits to emergency rooms,[22] and 2.1 million were hospitalized.[23] The medical care used by

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United States, 2007 & 2008, *available at* http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp (follow "Household Component summary tables" hyperlink; then select 2007 or 2008 for "year" and follow the "search" hyperlink; then follow the hyperlink next to "Table 1").

The Medical Expenditure Panel Survey ("MEPS") is a set of large-scale surveys of families and individuals, their medical providers (including doctors, hospitals, and pharmacies), and employers across the United States. It is conducted under the auspices of HHS.

[21] June E. O'Neill & Dave M. O'Neill, *Who Are the Uninsured? An Analysis of America's Uninsured Population, Their Characteristics and Their Health*, EMP'T POLICIES INSTITUTE, 21 tbl.9 (2009), *available at* http://epionline.org/studies/oneill_06-2009.pdf.

[22] Br. of *Amici Curiae* Am. Hosp. Ass'n *et al.* in Support of the Government at 11 (citing Press Release, HHS, New Data Say Uninsured Account for Nearly One-Fifth of Emergency Room Visits (Jul. 15, 2009), *available at* http://www.hhs.gov/news/press/2009pres/07/20090715b.html).

[23] In 2008, U.S. hospitals reported more than 2.1 million hospitalizations of the uninsured. Office of the Assistant Sec'y for Planning and Evaluation, HHS, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills* 5 (2011), *available at* http://aspe.hhs.gov/health/reports/2011/valueofinsurance/rb.shtml.

each uninsured person cost about $2,000 on average in 2007, and $1,870 on average in 2008.[24]

When the uninsured do seek health care, what happens? Some pay in full. Some partially pay. Some pay nothing. Data show the uninsured paid on average 37% of their health care costs out of pocket in 2007, and 46.01% in 2008,[25] while third parties pay another 26% on their behalf.[26] Not surprisingly, the poorer uninsured, on average, consume more health care for which they do not pay.[27] Even in households at or above the median income level

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[24] MEPS Summary Tables, *supra* note 20. An Economic Scholars' *amici* brief, filed in support of the government, states: "The medical care used by each uninsured person costs about $2000 per year, on average." Br. of *Amici Curiae* Economists in Support of the Government at (citing "Agency for Health Care Quality and Research, Medical Expenditure Panel Survey, Summary Data Tables, Table 1" (*see* MEPS Summary Tables, *supra* note 20); Jack Hadley, *et al.*, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," 27(5) HEALTH AFFAIRS W399-415 (2008)).

In contrast, this same *amici* brief points out: "In 2007, the average person used $6,186 in personal health care services." *Id.* at 11 (citing "Center for Medicare and Medicaid Services, National Health Expenditure Accounts"); *see* CMS, *National Expenditure Web Tables*, *supra* note 10, at tbl.1.

[25] *See* MEPS Summary Tables, *supra* note 20.

[26] *See* Families USA, *Hidden Health Tax*, *supra* note 8, at 2 (cited by both the plaintiffs and the government).

[27] Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. HEALTH ECON. 225, 229–31 (2005).

($41,214) in 2000, the uninsured paid, on average, less than half their medical care costs.[28]

It is also undisputed that people are uninsured for a wide variety of reasons. The uninsured are spread across different income brackets:

(1) less than $25,000: 15.5 million uninsured, or about 31%;

(2) $25,000 to $49,999: 15.3 million uninsured, or about 30%;

(3) $50,000 to $74,999: 9.4 million uninsured, or about 18%;

(4) $75,000 or more: 10.6 million uninsured, or about 21%.[29]

As the data show, many of the uninsured have low to moderate incomes and simply cannot afford insurance. Some of the uninsured can afford insurance and tried to obtain it, but were denied coverage based on health status.[30] Some are voluntarily uninsured and self-finance because they can pay for their medical care or have modest medical care needs. Some may not have considered the issue. There is no one reason why people are uninsured. It is also not surprising, therefore, that

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[28] Herring, *supra* note 27, at 231 ("[T]he median income for all household[s] in the U.S. is roughly 300% of poverty, and the poverty threshold was US$13,738 for a family of three in 2000."); *see id.* at 230 tbl.1.

[29] *See Census Report*, *supra* note 7, at 23 tbl.8.

[30] *See* HHS, *Coverage Denied*, and *Collins*, *supra* note 14.

Congress has attacked the uninsured problem through multiple reforms and numerous avenues in the Act that we outline later.

Given these identified problems, congressional findings, and data as background, we now turn to Congress's legislative response in the Act.

B. Overall Structure of Nine Titles

The sweeping and comprehensive nature of the Act is evident from its nine Titles:

I. Quality, Affordable Health Care for All Americans
II. Role of Public Programs
III. Improving the Quality and Efficiency of Health Care
IV. Prevention of Chronic Disease and Improving Public Health
V. Health Care Workforce
VI. Transparency and Program Integrity
VII. Improving Access to Innovative Medical Therapies
VIII. Community Living Assistance Services and Supports
IX. Revenue Provisions[31]

The Act's provisions are spread throughout many statutes and different titles in the United States

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[31] There is also a tenth Title dedicated to amendments to these nine Titles.

Code. As our Appendix A demonstrates, the Act's nine Titles contain hundreds of new laws about hundreds of different areas of health insurance and health care. Appendix A details most parts of the Act with section numbers. Here, we merely list the broad subject matter in each Title.

Title I contains these four components mentioned earlier: (1) the insurance industry reforms; (2) the new state-run Exchanges; (3) the individual mandate; and (4) the employer penalty. Act §§ 1001–1568. Title II shifts the Act's focus to publicly-funded programs designed to provide health care for the uninsured, such as Medicaid, CHIP, and initiatives under the Indian Health Care Improvement Act. *Id.* §§ 2001–2955. Title II contains the Medicaid expansion at issue here. Title II's provisions also create, or expand, other publicly-funded programs. *Id.*

Title III primarily addresses Medicare. *Id.* §§ 3001–3602. Title IV concentrates on prevention of illness. *Id.* §§ 4001–4402. Title V seeks to increase the supply of health care workers through education loans, training grants, and other programs. *Id.* §§ 5001–5701.

Title VI creates new transparency and anti-fraud requirements for physician-owned hospitals participating in Medicare and for nursing facilities participating in Medicare or Medicaid. *Id.* §§ 6001–6801. Title VI includes the Elder Justice Act, designed to eliminate elder abuse, neglect, and exploitation. *Id.*

Title VII extends and expands certain drug discounts in health care facilities serving low-income patients. *Id.* §§ 7001–7103. Title VIII establishes a national, voluntary long-term care insurance program for purchasing community living assistance services and support by persons with functional limitations. *Id.* §§ 8001–8002. Title IX contains revenue provisions. *Id.* §§ 9001–9023.

We include Appendix A because it documents (1) the breadth and scope of the Act; (2) the multitudinous reforms enacted to reduce the number of the uninsured; (3) the large number and diverse array of new, or expanded, federally-funded programs, grants, studies, commissions, and councils in the Act; (4) the extensive new federal requirements and regulations on myriad subjects; and (5) how many of the Act's provisions on their face operate separately and independently.

We now examine in depth the five parts of the Act largely designed to reduce the number of the uninsured. Because of the Act's comprehensive and complex regulatory scheme, it is critical to examine what the Act actually does and does not do. We start with some terms and definitions.

C. Terms and Definitions

The Act regulates three aspects of health insurance: (1) "markets," the outlets where consumers may purchase insurance products; (2) "plans," the insurance products themselves; and (3) "benefits," the health care services or items covered under an insurance plan.

1. Markets

Given its focus on making health insurance available to the uninsured, the Act recognizes and regulates four markets for health insurance products: (1) the "individual market"; (2) the "small group market"; (3) the "large group market"; and (4) the new Exchanges, to be created and run by each state.

The term "individual market" means "the market for health insurance coverage offered to individuals other than in connection with a group health plan." 42 U.S.C. §§ 300gg-91(e)(1)(A), 18024(a)(2).

The term "group market" means "the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer." *Id.* § 18024(a)(1).

Within the "group market," the Act distinguishes between the "large group market" and the "small group market." The term "large group market" refers to the market under which individuals purchase coverage through a group plan of a "large employer." *Id.* §§ 300gg-91(e)(3), 18024(a)(3). A "large employer" is an employer with over 100 employees. *Id.* §§ 300gg-91(e)(2), 18024(b)(1).

The term "small group market" refers to the market under which individuals purchase coverage through a group plan of a "small employer," or an employer with no more than 100 employees. *Id.* §§ 300gg-91(e)(4), (5), 18024(a)(3), (b)(2).

The term "Exchanges" refers to the health benefit exchanges that each state must create and operate.[32] *Id.* 32 § 18031(b). Companies (profit and nonprofit) participating in the Exchanges will offer insurance for purchase by individuals and employees of small employers. *See id.*; *id.* § 18042. The uninsured can obtain significant federal tax credits and subsidies through the Exchanges. *See* 26 U.S.C. § 36B; 42 U.S.C. § 18071. In 2017, the states will have the option to open the Exchanges to large employers. 42 U.S.C. § 18032(f)(2)(B).

2. "Essential Health Benefits Package" Term

Two key terms in the Act are: (1) "essential health benefits package" and (2) "minimum essential coverage." Although they sound similar, each has a different meaning.

The term "essential health benefits package" refers to the comprehensive benefits package that must be provided by plans in the individual and small group markets by 2014. *Id.* § 300gg-6(a) (effective Jan. 1, 2014); *id.* § 18022(a). The Act does not impose the essential health benefits package on plans offered by large group employers to their employees.

An "essential health benefits package" must: (1) provide coverage for the "essential health benefits" described in § 18022(b); (2) limit the insured's cost-sharing, as provided in § 18022(c); and (3) provide "either the bronze, silver, gold, or platinum level of coverage" described in § 18022(d). *Id.* § 18022(a).

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[32] The Act allows a state to opt out of creating and operating an Exchange, in which case the federal government (or a nonprofit contractor) will establish the Exchange. 42 U.S.C. § 18041(c).

The Act leaves it to HHS to define the term "essential health benefits." *Id.* § 18022(b). However, that definition of "essential health benefits" must include at least these ten services:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

Id. § 18022(b)(1).[33] The bronze, silver, gold, and platinum levels of coverage reflect the levels of cost-sharing (or actuarial value of benefits) in a plan and do not represent the level or type of services. *Id.* § 18022(d)(1)–(2). For example, a bronze plan covers 60% of the benefits' costs, and the insured pays 40% out of pocket; a platinum plan covers 90%, with the insured paying 10%. *Id.* § 18022(d)(1)(A), (D).

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[33] In defining "essential health benefits," HHS must ensure that the scope of essential health benefits is "equal to the scope of benefits provided under a typical employer plan." 42 U.S.C.

3. Individual Mandate's "Minimum Essential Coverage" Term

The Act uses a wholly different term—"minimum essential coverage"—in connection with the individual mandate. "Minimum essential coverage" is the type of *plan* needed to satisfy the individual mandate. A wide variety of health plans are considered "minimum essential coverage": (1) government-sponsored programs, (2) eligible employer-sponsored health plans, (3) individual market health plans, (4) grandfathered health plans, and (5) health plans that qualify for, and are offered in, a state-run Exchange. 26 U.S.C. § 5000A(a), (f)(1).

Many of these plan types will satisfy the mandate even if they do not have the "essential health benefits package" and regardless of the level of benefits or coverage. The requirement of the "essential health benefits package" is directly tied to some of the insurance product reforms, but not the individual mandate.

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§ 18022(b)(2). HHS must take additional elements into consideration, such as balance among the categories of benefits, discrimination based on age or disability, and the needs of diverse segments of the population. *Id.* § 18022(b)(4).

We turn to the Act's first component: the insurance reforms.

D. Health Insurance Reforms

To reduce the number of the uninsured, the Act heavily regulates private insurers and reforms their health insurance products. We list examples of the major reforms.

1. Guaranteed Issue. Insurers must permit every employer or individual who applies in the individual or group markets to enroll. 42 U.S.C. § 300gg-1(a) (effective Jan. 1, 2014). However, insurers "may restrict enrollment in coverage described [in subsection (a)] to open or special enrollment periods."[34] *Id.* § 300gg-1(b)(1) (effective Jan. 1, 2014).

2. Guaranteed renewability. Insurers in the individual and group markets must renew or continue coverage at the individual or plan sponsor's option in the absence of certain exceptions, such as premium nonpayment, fraud, or the insurer's discontinuation of coverage in the relevant market. *Id.* § 300gg-2(b).

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[34] The Act directs HHS to promulgate regulations with respect to enrollment periods. 42 U.S.C. § 300gg-1(b)(3) (effective Jan. 1, 2014). Insurers must establish "special enrollment periods for 'qualifying events.'" *Id.* § 300gg-1(b)(2). "Qualifying events" include, for example: (1) "[t]he death of the covered employee"; (2) "[t]he termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment"; and (3) "[t]he divorce or legal separation of the covered employee from the employee's spouse." 29 U.S.C. § 1163.

3. Waiting periods. Under group health plans, insurers may impose waiting periods of up to 90 days before a potential enrollee is eligible to be covered under the plan. *Id.* §§ 300gg-7 (effective Jan. 1, 2014), 300gg-3(b)(4). The Act places no limits on insurers' waiting periods for applications in the individual market.

4. Elimination of preexisting conditions limitations. Insurers may no longer deny or limit coverage due to an individual's preexisting medical conditions. The Act prohibits preexisting condition exclusions for children under 19 within six months of the Act's enactment, and eliminates preexisting condition exclusions for adults beginning in 2014.[35] *Id.* § 300gg-3.

5. Prohibition on health status eligibility rules. Insurers may not establish eligibility rules based on any of the health status-related factors listed in the Act.[36]

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[35] For dates effective as to children and then adults, *see* Pub. L. No. 111-148, Title I, § 1255 (formerly §1253), 124 Stat. 162 (2010) (renumbered § 1255 and amended, Pub. L. No. 111-148, Title X, § 10103(e), (f)(1), 124 Stat. 895 (2010), and codified in note to 42 U.S.C. § 300gg-3).

[36] Health status-related factors include:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

Id. § 300gg-4 (effective Jan. 1, 2014).

6. Community rating. In the individual and small group markets and the Exchanges, insurers may vary premium rates only based on (1) whether the plan covers an individual or a family; (2) "rating area"; (3) age (limited to a 3–to–1 ratio); and (4) tobacco use (limited to a 1.5–to–1 ratio). *Id.* § 300gg(a)(1). Each state must establish one or more rating areas subject to HHS review. *Id.* § 300gg(a)(2)(B). This rule prevents insurers from varying premiums within a geographic area based on gender, health status, or other factors.

7. Essential health benefits package. The individual and small group market plans must contain comprehensive coverage known as the "essential health benefits package," defined above. *Id.* §§ 300gg-6(a) (effective Jan. 1, 2014), 18022(a). The Act does not impose this requirement on large group market plans.[37]

> (5) Medical history.
>
> (6) Genetic information.
>
> (7) Evidence of insurability (including conditions arising out of acts of domestic violence).
>
> (8) Disability.
>
> (9) Any other health status-related factor determined appropriate by the [HHS] Secretary.

42 U.S.C. § 300gg-4(a) (effective Jan. 1, 2014).

[37] Rather, the large group market is subject to only a few coverage-reform requirements that apply broadly to either *all*

8. Preventive service coverage. Insurers must provide coverage for certain enumerated preventive health services without any deductibles, copays, or other cost-sharing requirements. *Id.* § 300gg-13(a).

9. Dependent coverage. Insurers must allow dependent children to remain on their parents' policies until age 26. *Id.* § 300gg-14(a).

10. Elimination of annual and lifetime limits. Insurers may no longer establish lifetime dollar limits on essential health benefits. *Id.* § 300gg-11(a)(1)(A), (b). Insurers may retain annual dollar limits on essential health benefits until 2014.[38] *Id.* § 300gg-11(a).

11. Limits on cost-sharing by insureds. "Cost-sharing"[39] includes out-of-pocket "deductibles, coinsurance, copayments, or similar charges" and

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insurance plans or group health plans in particular. *See* Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 147 (2011).

[38] HHS shall determine what restricted annual limits are permitted on the dollar value of essential health benefits until 2014. 42 U.S.C. § 300gg-11(a)(1), (2). "Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits . . . ." *Id.* § 300gg-11(b).

[39] "Cost-sharing" does not include "premiums, balance billing amounts for non-network providers, or spending for non-covered services." 42 U.S.C. § 18022(c)(3)(B).

"qualified medical expenses."[40] *Id.* § 18022(c)(3)(A). Annual cost-sharing limits apply to group health plans, health plans sold in the individual market, and qualified health plans offered through an Exchange.[41] *Id.* §§ 300gg-6(b) (effective Jan. 1, 2014), 18022(a), (c).

12. Deductibles. Deductibles for any plans offered in the small group market are capped at $2,000 for plans covering single individuals and $4,000 for any other plan, adjusted after 2014. *Id.* §§ 300gg-6(b) (effective Jan. 1, 2014), 18022(c)(2). The deductible limits do not apply to individual plans or large group plans. *See id.*

13. Medical loss ratio. Insurers must maintain certain ratios of premium revenue spent on the insureds' medical care versus overhead expenses. *Id.* § 300gg-18(a), (b)(1). In the large group market, insurers must spend 85% of their premium revenue on patient care and no more than 15% on overhead. *Id.* § 300gg-18(a), (b)(1)(A)(i). In the individual and small group markets, insurers must spend 80% of their revenue on patient care and no more than 20% on overhead. *Id.* § 300gg-18(a), (b)(1)(A)(ii). This medical-loss ratio requirement applies to all plans (including grandfathered plans). *Id.* § 300gg-18(a), (b)(1). Insurers must report to HHS their ratio of incurred claims to earned premiums. *Id.* § 300gg-18(a).

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[40] "Qualified medical expense" is defined in 26 U.S.C. § 223(d)(2).

[41] Annual limits on cost-sharing are equal to the current limits on out-of-pocket spending for high-deductible health plans under the Internal Revenue Code (for 2011, $5,950 for self-only coverage and $11,900 for family coverage), adjusted after 2014 by a "premium adjustment percentage." 42 U.S.C. §§ 300gg-6(b) (effective Jan. 1, 2014), 18022(c)(1); 26 U.S.C. § 223(c)(2)(A)(ii), (g); I.R.S. Pub. 969 (2010), at 3.

14. Premium increases. HHS, along with all states, shall annually review "unreasonable" increases in premiums beginning in 2010. *Id.* § 300gg-94(a)(1). Issuers must justify any unreasonable premium increase. *Id.* § 300gg-94(a)(2).

15. Prohibition on coverage rescissions. Insurers may not rescind coverage except for fraud or intentional misrepresentation of material fact. *Id.* § 300gg-12.

16. Single risk pool. Insurers must consider all individual-market enrollees in their health plans (except enrollees in grandfathered plans) to be members of a single risk pool (whether enrolled privately or through an Exchange). *Id.* § 18032(c)(1). Small group market enrollees must be considered in the same risk pool. *Id.* § 18032(c)(2).

17. Temporary high risk pool program. To cover many of the uninsured immediately, the Act directs HHS to establish a "temporary high risk health insurance pool program" to offer coverage to uninsured individuals with preexisting conditions until the prohibition on preexisting condition exclusions for adults becomes effective in 2014. *Id.* § 18001(a). The premiums for persons with a preexisting condition remain what a healthy person would pay. *Id.* §§ 18001(c)(2)(C), 300gg(a)(1). The Act allocates $5 billion to HHS to cover this high-risk pool. When this temporary program ends in 2014, such individuals will be transferred to coverage through an Exchange. *Id.* § 18001(a)–(d), (g).

18. State regulation maintained. States will license insurers and enforce both federal and state insurance laws. *Id.* § 18021(a)(1)(C). The Act provides for the continued operation of state regulatory authority, even with respect to interstate "health care choice compacts," which enable qualified health plans to be offered in more than one state.[42] *Id.* § 18053(a).

In addition to reforming health insurance products, the Act requires the creation of Exchanges where the uninsured can buy the new products. We examine this second component of the Act, also designed to make insurance more accessible and affordable and thus reduce the number of the uninsured.

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[42] Health care choice compacts allow qualified health plans to be offered in the individual markets of multiple states, yet such plans will "only be subject to the laws and regulations of the State in which the plan was written or issued." 42 U.S.C. § 18053(a)(1)(A). The issuer of such qualified health plans offered through health care choice compacts "would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards . . . of the State in which the purchaser resides" and "would be required to be licensed in each State in which it offers the plan under the compact." *Id.* § 18053(a)(1)(B)(i)–(ii).

E. Health Benefit Exchanges

1. Establishment of State-Run Exchanges

By January 1, 2014, all states must establish "American Health Benefit Exchanges" and "Small Business Health Options Program Exchanges," which are insurance marketplaces where individuals, families, and small employers can shop for the Act's new insurance products. *Id.* § 18031(b). Consumers can compare prices and buy coverage from one of the Exchange's issuers. *Id.* § 18031(b), (c). Exchanges centralize information and facilitate the use of the Act's significant federal tax credits and other subsidies to purchase health insurance. *See* 26 U.S.C. § 36B; 42 U.S.C. §§ 18031, 18071, 18081–83. States may create and run the Exchanges through a governmental or nonprofit entity. 42 U.S.C. § 18031(d)(1).

States may establish regional, interstate, or subsidiary Exchanges. *Id.* § 18031(f). The federal government will provide funding until January 1, 2015 to establish Exchanges. *Id.* § 18031(a). Insurers may offer their products inside or outside these Exchanges, or both. *Id.* § 18032(d).

Importantly, the Exchanges draw upon the states' significant experience regulating the health insurance industry. *See id.* § 18041. The Act allows states some flexibility in operations and enforcement, though states must either (1) directly adopt the federal requirements set forth by HHS, or (2) adopt state regulations that effectively implement the federal standards, as determined by HHS. *Id.* § 18041(b). In a subsection entitled, "No interference with State regulatory authority," the

Act provides that "[n]othing in this chapter shall be construed to preempt any State law that does not prevent the application of the provisions of this chapter." *Id.* § 18041(d).

2. Qualified Individuals and Employers in the Exchanges

The Act provides that "qualified individuals" and "qualified employers" may purchase insurance through the Exchanges. *Id.* § 18031(d)(2). Although "qualified individuals" is broadly defined,[43] "qualified employers" are initially limited to small employers, but in 2017, states may allow large employers to participate in their Exchanges. *Id.* § 18032(f)(2)(A), (B). Qualified employers can purchase group plans in or out of Exchanges. *Id.* § 18032(d)(1).

3. Qualified Health Plans in the Exchanges

The Act prescribes the types of plans available in the Exchanges, known as "qualified health plans." *Id.* § 18031(d)(2)(B)(i). A "qualified health plan" is a health plan that: (1) is certified as a qualified health plan in each Exchange through which the plan is offered; (2) provides an "essential health benefits package"; and (3) is offered by an issuer that (a) is licensed and in good standing in each state where it offers coverage, and (b) complies with HHS regulations and any requirements of the Exchange. *Id.* § 18021(a)(1). The issuer must agree, *inter alia*, to offer at least one plan in the "silver" level and one in the "gold" level in each Exchange in which it participates, as described in § 18022(d). *Id.* § 18021(a)(1)(C). The issuer must charge the same premium rate regardless of whether a plan is offered in an Exchange or directly.[44] *Id.*

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[43] A "qualified individual" is a legal resident who (1) seeks to enroll in a "qualified health plan" in the individual market through the Exchange, and (2) resides in the state that established the Exchange. 42 U.S.C. § 18032(f)(1), (3). Prisoners and illegal aliens may not purchase insurance through Exchanges. *Id.* § 18032(f)(1)(B), (3).

4. "Essential Health Benefits Package" and Catastrophic Plans

The "essential health benefits package" is required of all qualified health plans sold in the Exchanges. *Id.* § 18021(a)(1)(B). States may require that a qualified health plan offered in that state cover benefits in addition to "essential health benefits," but the state must defray the costs of additional coverage through payments directly to patients or insurers. *Id.* § 18031(d)(3)(B).

One significant exception to the "essential health benefits package" requirement is the catastrophic plan in the individual market only. In and outside the Exchanges, insurers may offer catastrophic plans which provide no benefits until a certain level of out-of-pocket costs—$5,950 for self-only coverage and $11,900 for family coverage in 2011—are incurred. *Id.* § 18022(e); *see id.* § 18022(c)(1), (e)(1)(B)(i); 26 U.S.C. § 223(c)(2)(A)(ii), (g); I.R.S. Pub. 969 (2010), at 3. The level of out-of-pocket costs is equal to the current limits on out-of-pocket spending for high deductible health plans adjusted after 2014. 42 U.S.C. § 18022(e), (c)(1).

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[44] HHS establishes the criteria for certification of insurance plans as "qualified health plans" and develops a rating system to "rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price." 42 U.S.C. § 18031(c)(1), (3). States must rate each health plan offered in an Exchange (in accordance with federal standards) and certify health plans as "qualified health plans." *See id.* § 18031(e).

This catastrophic plan exception applies only if the plan: (1) is sold in the individual market; (2) restricts enrollment to those under age 30 or certain persons exempted from the individual mandate; (3) provides the essential health benefits coverage after the out-of-pocket level is met; and (4) provides coverage for at least three primary care visits. *Id.* § 18022(e)(1), (2).

5. Federal Premium Tax Credit

To reduce the number of the uninsured, the Act also establishes considerable federal tax credits for individuals and families (1) with household incomes between 1 and 4 times the federal poverty level; (2) who do not receive health insurance through an employer; and (3) who purchase health insurance through an Exchange.[45] 26 U.S.C. § 36B(a), (b), (c)(1)(A)–(C).

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[45] Specifically, the amount of the federal tax credit for a given month is an amount equal to the lesser of (1) the monthly premiums for the qualified health plan or plans, offered in the individual market through an Exchange, that cover the taxpayer and the members of the taxpayer's household, *or* (2) the excess of: (a) the monthly premium the taxpayer would be charged for the second lowest-cost silver plan over (b) 1/12 of

To receive the credit, eligible individuals must enroll in a plan offered through an Exchange and report their income to the Exchange. 42 U.S.C. § 18081(b). If the individual's income level qualifies, the Treasury pays the premium tax credit amount directly to the individual's insurance plan issuer. *Id.* § 18082(c)(2)(A). The individual pays only the dollar difference between the premium tax credit and the total premium charged. *Id.* § 18082(c)(2)(B). The credit amount is tied to the cost of the second-cheapest plan in the silver level offered through an Exchange where the individual resides, though the credit may be used for any plan purchased through an Exchange.[46] *See* 26 U.S.C. § 36B(b)(2).

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the taxpayer's yearly household income multiplied by the "applicable percentage," a percentage which ranges from 2.0% to 9.5%, depending on income. 26 U.S.C. § 36B(b)(3)(A)–(C).

An example helps translate. For a family of four with an income of $33,075 per year, assuming that the premium in the second lowest-cost silver plan covering the family is $4,500 per year ($375 per month), the federal tax credit would be $3,177 per year ($264.75 per month). *See* Families USA, *Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit* 8 (2010), *available at* http://www.familiesusa.org/assets/pdfs/health-reform/Premium-Tax-Credits.pdf. Without the federal tax credit, the family pays $375 per month; with the credit, the family pays $110.25 per month, or a total of $1,323, instead of the full $4,500 premium. *Id.* The federal tax credit provides a major incentive for the uninsured (in the individual market) to purchase insurance from a private insurer but through the Exchange.

[46] Commentators have explained the operation of the tax credit for households between one and four times the federal poverty level as follows:

6. Federal Cost-Sharing Subsidies

The Act also provides a variety of federal cost-sharing subsidies to reduce the out-of-pocket expenses for individuals who (1) enroll in a qualified health plan sold through an Exchange in the silver level of coverage, and (2) have a household income between 1 and 4 times the federal poverty level. 42 U.S.C. § 18071.

As noted earlier, the Exchanges, with significant federal tax credits and subsidies, are predicted to make insurance available to 9 million in 2014 and 22

> For taxable years after 2013, certain low- and moderate-income individuals who purchase insurance under a health insurance exchange that the states are required to create will receive a refundable credit that subsidizes their purchase of that insurance. . . . According to the Social Security Administration, the current poverty level for a single individual is $10,830; thus a single individual can have household income of as much as $43,320 and still qualify to have his insurance cost subsidized by the government. For a family of four, the current poverty level is $22,050; such a family can have household income as large as $88,200 and still qualify for a subsidy.

Douglas A. Kahn & Jeffrey H. Kahn, *Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform*, 109 MICH. L. REV. FIRST IMPRESSIONS 78, 83 (2011).

HHS has since raised the poverty level for 2011 to $22,350 for a family of four and $10,890 for a single individual. 76 Fed. Reg. 3637, 3638 (Jan. 20, 2011). Thus, a single individual can have a household income of as much as $43,560 and still be eligible for a federal tax credit. A family of four can have a household income of as much as $89,400 and still be eligible for a federal tax credit. *See* 42 U.S.C. § 18071(b).

million by 2016.[47] We now turn to the Act's third component: the individual mandate.

F. Individual Mandate

The individual mandate and its penalty are housed entirely in the Internal Revenue Code, in subtitle D, labeled "Miscellaneous Excise Taxes." 26 U.S.C. § 5000A *et seq.* The Act mandates that, after 2013, all "applicable individuals" (1) shall maintain "minimum essential coverage" for themselves and their dependents, or (2) pay a monetary penalty. *Id.* § 5000A(a)–(b). Taxpayers must include the penalty on their annual federal tax return. *Id.* § 5000A(b)(2). Married taxpayers filing a joint return are jointly liable for any penalty. *Id.* § 5000A(b)(3)(B).

1. "Minimum Essential Coverage"

At first glance, the term "minimum essential coverage," as used in the Internal Revenue Code, sounds like it refers to a base level of benefits or services. However, the Act uses a different term—the "essential health benefits package" in Title 42—to describe health care benefits and services. 42 U.S.C. § 300gg-6(a) (effective Jan. 1, 2014). In contrast, "minimum essential coverage" refers to a broad array of plan types that will satisfy the individual mandate. 26 U.S.C. § 5000A(f)(1).

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[47] CBO, *Analysis*, *supra* note 15, at 18 tbl.3. The CBO predicts that by 2019, 24 million will be insured through the Exchanges, with at least four-fifths receiving "federal subsidies to substantially reduce the cost of purchasing health insurance coverage," on average $6,460 per person. *Id.* at 2, 18–19 tbl.3.

The CBO estimates that this 9 million increase in 2014 will be partially offset by a 3 million decrease in individual-market coverage outside the Exchanges. *Id.* The number obtaining coverage in the individual market outside the Exchanges is projected to decrease because the Act incentivizes individuals—through premium tax credits, subsidies, and otherwise—to purchase policies through the Exchanges. Similarly, the 22 million increase in Exchange-based coverage in 2016 will be partially offset by a 5 million decrease in those covered by individual-market policies obtained outside the Exchanges. *Id.*

An individual can satisfy the mandate's "minimum essential coverage" requirement through: (1) any government-funded health plan such as Medicare Part A, Medicaid, TRICARE, or CHIP; (2) any "eligible employer-sponsored plan"; (3) any health plan in the individual market; (4) any grandfathered health plan; or (5) as a catch-all, "such other health benefits coverage" that is recognized by HHS in coordination with the Treasury. *Id.* The mandate provisions in § 5000A do not specify what benefits must be in that plan. The listed plans, in many instances, satisfy the mandate regardless of the level of benefits or coverage.

2. Government-Sponsored Programs

For example, a variety of government-sponsored programs will satisfy the individual mandate. For individuals 65 or over, enrolling in Medicare Part A will suffice. *Id.* § 5000A(f)(1)(A)(i). Individuals and families may satisfy the mandate by enrolling in Medicaid, if eligible. *Id.* § 5000A(f)(1)(A)(ii). Qualifying children under age 19 can satisfy the mandate by enrolling in CHIP. *Id.* § 5000A(f)(1)(A)(iii). Government-sponsored programs for veterans, active and former military personnel and their families, active Peace Corps volunteers, and active and retired civilian Defense Department personnel and their dependents satisfy the mandate. *Id.* § 5000A(f)(1)(A)(iv), (v), (vi).

3. Eligible Employer-Sponsored Plans

Individuals may also satisfy the mandate by purchasing coverage through any "eligible employer-sponsored plan." *Id.* § 5000A(f)(1)(B). An "eligible employer-sponsored plan" is a "group health plan or group health insurance coverage" offered "by an employer to the employee," which is defined broadly as: (1) a governmental plan established by the federal, state, or local government for its employees; (2) "any other plan or coverage offered in the small or large group market within a State"; or (3) a grandfathered health plan offered in a group market. *Id.* § 5000A(f)(2). Health plans of large employers satisfy the individual mandate whatever the nature of the benefits offered to the employee.[48]

Whether a "self-insured health plan" of large employers satisfies the mandate is another story.[49]

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[48] Because of these looser restrictions, some commentators have found it surprising that employer-sponsored coverage qualifies as "minimum essential coverage" under the Act. *See* Monahan & Schwarcz, *supra* note 37, at 157 ("Surprisingly, . . . [the Act] appears to define employer-provided coverage as automatically constituting minimum essential coverage for individuals, despite the minimal requirements applicable to such plans.").

[49] The Act defines an "applicable self-insured health plan" to include self-insured plans providing health care coverage where "any portion of such coverage is provided other than through an insurance policy." 26 U.S.C. § 4376(c).

The mandate's § 5000A(f)(2) refers to plans in the "small or large group *market*." *Id.* § 5000A(f)(2). A "self-insured health plan," by definition, is not sold or offered in a "market." It is thus not clear whether large employers' self-insured plans will constitute "eligible employer-sponsored plans" in § 5000A(f)(2) and thereby satisfy the mandate. It may be that HHS will later recognize "self-insured plans" under the "other coverage" or "grandfathered plan" categories in the mandate's § 5000A(f)(2).

4. Plans in the Individual Market

Individuals can also satisfy the mandate by purchasing insurance in the individual market through Exchanges or directly from issuers. *Id.* § 5000A(f)(1)(C). The Act imposes the "essential health benefits package" requirement on plans sold in the individual and small group markets. 42 U.S.C. § 300gg-6 (effective Jan. 1, 2014). However, in the individual market, insurers can offer catastrophic plans to persons under age 30 or certain persons exempted from the mandate. *Id.* § 18022(e).

5. Grandfathered Plans

An already-insured individual can fulfill the individual mandate by being covered by any "grandfathered health plan," 26 U.S.C. § 5000A(f)(1)(D), which is any group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010.[50] 42 U.S.C. § 18011(a)(1), (e).

While not subject to many of the Act's product reforms, grandfathered plans must comply with some provisions, among them the extension of dependent coverage until age 26, the medical-loss ratio requirements, and the prohibitions on (1) preexisting condition exclusions, (2) lifetime limits on coverage, (3) excessive waiting periods, and (4) unfair rescissions of coverage. *Id.* § 18011(a)(2)–(4), (e). Under the "interim final regulations" issued by HHS, plans will lose their grandfathered status if they choose to significantly (1) cut or eliminate benefits; (2) increase copayments, deductibles, or out-of-pocket costs for their enrollees; (3) decrease the share of premiums employers contribute for workers in group plans; or (4) decrease annual limits.[51] 45 C.F.R. § 147.140(g).

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[50] The Act also allows the enrollment of family members and newly hired employees in grandfathered plans without losing the plans' grandfathered status. 42 U.S.C. § 18011(b), (c). Under the "interim final regulations" issued by HHS, "[a] group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person)." 45 C.F.R. § 147.140(a)(1)(i).

[51] *See also* HealthReform.gov, *Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered" Health Plans*, http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html; Families USA, *Grandfathered Plans under the Patient Protection and*

6. "Other Coverage Recognized" by HHS

The individual mandate even provides a catch-all that leaves open the door to other health coverage. The "minimum essential coverage" requirement may be met by any other coverage that HHS, in coordination with the Treasury, recognizes for purposes of meeting this requirement. 26 U.S.C. § 5000A(f)(1)(E).

7. Exemptions and Exceptions to Individual Mandate

The individual mandate, however, does not apply to eight broad categories of persons, either by virtue of an exemption from the mandate or an exception to the mandate's penalty. The Act carves out these three exemptions from the individual mandate: (1) persons with religious exemptions; (2) aliens not legally present in the country; and (3) incarcerated persons. *Id.* § 5000A(d).

The Act also excepts five additional categories of persons from the individual mandate penalty: (1) individuals whose required annual premium contribution exceeds 8% of their household income for the taxable year;[52] (2) individuals whose household income for the taxable year is below the federal income tax filing threshold in 26 U.S.C.

Affordable Care Act (2010), *available at* http://www.familiesusa.org/assets/pdfs/health-reform/Grandfathered-Plans.pdf.

[52] The required contribution for coverage means, generally, the amount required to maintain coverage either in an employer-sponsored health plan or in a bronze-level plan offered on an Exchange. *See* 26 U.S.C. § 5000A(e)(1)(A).

§ 6012(a)(1); (3) members of Indian tribes; (4) individuals whose gaps in health insurance coverage last less than three months; and (5) as a catch-all, individuals who, as determined by HHS, have suffered a "hardship" regarding their ability to obtain coverage under a qualified health plan. *Id.* § 5000A(e).

8. Calculation of Individual Mandate Penalty

If an applicable individual fails to purchase an insurance plan in one of the many ways allowed, the individual must pay a penalty. *Id.* § 5000A(b)(1). The annual penalty will be either: (1) a flat dollar amount, or (2) a percentage of the individual's income if higher than the flat rate. *Id.* § 5000A(c)(1). However, the percentage-of-income figure is capped at the national average premium amount for bronze-level plans in the Exchanges.[53] *Id.*

The flat dollar penalty amount, which sets the floor, is equal to $95 in 2014, $325 in 2015, and $695 in 2016. *Id.* § 5000A(c)(2)(A), (c)(3)(A)–(C). Beyond 2016, it remains $695, except for inflation adjustments.[54] *Id.* § 5000A(c)(3)(D).

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[53] If the individual fails to fulfill the mandate requirement for only certain months as opposed to a full year, the penalty for each month of no coverage is equal to one-twelfth of the greater of these figures. 26 U.S.C. § 5000A(c)(2)–(3).

[54] The flat dollar amount applies to each individual and dependent in the taxpayer's household without minimum essential coverage, but will not exceed three times the flat dollar amount (even if more than three persons are in the

The percentage-of-income number that will apply, if higher than the flat dollar amount, is a set percentage of the taxpayer's income that is in excess of the tax-filing threshold (defined in 26 U.S.C. § 6012(a)(1)).[55] *Id.* § 5000A(c)(2). In any event, the total penalty for the taxable year cannot exceed the national average premium of a bronze-level qualified health plan. *Id.* § 5000A(c)(1).

9. Collection of Individual Mandate Penalty

An individual who fails to pay the penalty is not subject to criminal or additional civil penalties. *Id.* § 5000A(g)(2)(A), (B). The IRS's authority to use liens or levies does not apply to the penalty. *Id.* § 5000A(g)(2)(B). No interest accrues on the penalty. The Act contains no enforcement mechanism. *See id.* All the IRS, practically speaking, can do is offset any tax refund owed to the uninsured taxpayer.[56]

We now review the Act's fourth component aimed at reducing the number of the uninsured: the employer penalty.

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household). 26 U.S.C. § 5000A(c)(2)(A). A family's flat dollar penalty in 2016 would not exceed $2,085 ($695 multiplied by 3).

[55] The percentage by which the taxpayer's household income exceeds the filing threshold is phased in over three years: 1% in 2014, 2% in 2015, and 2.5% in 2016 and thereafter. 26 U.S.C. § 5000A(c)(2)(B)(i)–(iii).

[56] Of course, the government can always file a civil lawsuit, but the cost of that suit would exceed the modest penalty amount.

G. Employer Penalty

The Act imposes a penalty, also housed in the Internal Revenue Code, on certain employers if they do not offer coverage, or offer inadequate coverage, to their employees. *Id.* § 4980H(a), (b). The penalty applies to employers with an average of at least 50 full-time employees. *Id.* § 4980H(a), (b), (c)(2). The employer must pay a penalty if the employer: (1) does not offer its full-time employees the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan" as defined in § 5000(A)(f)(2); *or* (2) offers minimum essential coverage (i) that is "unaffordable," or (ii) that consists of a plan whose share of the total cost of benefits is less than 60% (*i.e.*, does not provide "minimum value"); *and* (3) at least one full-time employee purchases a qualified health plan through an Exchange and is allowed a premium tax credit or a subsidy. *Id.* § 4980H(a), (c).

The employer penalty is tied to an employer's failure to offer "minimum essential coverage." *Id.* § 4980H(a), (b). Recall that "minimum essential coverage" is not the same thing as the "essential health benefits package." Thus, a large employer may avoid the penalty so long as it offers any plan in the large group market in the state, and the plan is "affordable" and provides "minimum value." *Id.* § 4980H(b)(1), (c)(3).

A small employer's plan, however, must include an "essential health benefits package" and also be "affordable" and provide "minimum value." 42 U.S.C. §§ 300gg-6(a) (effective Jan. 1, 2014), 18022(a)(1)–(3). The Act also provides tax incentives for certain small employers (up to 25 employees) to purchase health insurance for their workers. 26 U.S.C. § 45R.

1. Calculation of Penalty Amount

The penalty amount depends on whether the employee went to the Exchange because the employer's plan (1) was not "minimum essential coverage" or (2) was either "unaffordable" or did not provide "minimum value." The penalty translates to $2,000 to $3,000 per employee annually. *Id.* § 4980H.

An employer that does not offer "minimum essential coverage" to all fulltime employees faces a tax penalty of $166.67 per month (one-twelfth of $2,000) for each of its full-time employees, until the employer offers such coverage (subject to an exemption for the first 30 full-time employees). *Id.* § 4980H(a), (c)(1), (c)(2)(D). This particular penalty applies for as long as at least one employee, eligible for a premium tax credit or a subsidy, enrolls in a qualified health plan through an Exchange. *Id.*

In the "unaffordable coverage"[57] or "no minimum value" scenarios, the employer faces a tax penalty of

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[57] Employer-sponsored coverage that is not "affordable" is defined as coverage where the employee's required annual contribution to the premium is more than 9.5% of the employee's household income (as defined for purposes of the premium tax credits in the Exchanges). 26 U.S.C. § 36B(c)(2)(C)(i). This percentage of the employee's income is indexed to the per capita growth in premiums for the insurance market as determined by HHS. *Id.* § 36B(c)(2)(C)(iv). Note that the definition of "unaffordable" for the purposes of obtaining a federal tax credit or subsidy is *not* the same standard that is used to determine whether an individual is exempt from the

$250 per month (one-twelfth of $3,000) for each employee who (1) turns down the employer-sponsored plan; (2) purchases a qualified health plan in an Exchange; and (3) is eligible for a federal premium tax credit or subsidy in an Exchange.[58] *Id.* § 4980H(b)(1).

2. Automatic Enrollment

An automatic enrollment requirement applies to employers who (1) have more than 200 employees and (2) elect to offer coverage to their employees. *Id.* § 218a. Such employers must automatically enroll new and current full-time employees, who do not opt out, in one of the employer's plans. *Id.* The maximum 90-day waiting period rule applies, however. *Id.*; 42 U.S.C. § 300gg-7 (effective Jan. 1, 2014).

3. Temporary Reinsurance Program for Employers' Early Retirees

To reduce the number of the uninsured, the Act provides for immediate coverage for even retired employees 55 years and older who are not yet eligible for Medicare. A federal temporary

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individual mandate because that individual cannot afford coverage. *Compare id.* § 36B(c)(2)(C)(i), *with id.* § 5000A(e)(1).

[58] The employer's penalty, in this instance, does not exceed the maximum penalty for offering no coverage at all. The penalty for any month is capped at an amount equal to the number of full-time employees during the month multiplied by one-twelfth of $2,000, or $166.67 (subject to the exemption for the first 30 full-time employees). *See* 26 U.S.C. § 4980H(b)(2), (c).

reinsurance program will reimburse former employers who allow their early retirees and the retirees' dependents and spouses to participate in their employment-based plans. The federal government will reimburse a portion of the plan's cost.[59] 42 U.S.C. § 18002(a)(1), (a)(2)(C).

We turn to the Act's fifth component: the Medicaid expansion, which alone will cover millions of the uninsured.

H. Medicaid Expansion

The Act expands Medicaid eligibility and subsidies by amending 42 U.S.C. § 1396a, the section of the Medicaid Act outlining what states must offer in their coverage plans. The Act imposes these substantive requirements on the states' plans, starting in 2014, unless otherwise noted:

(1) States will be required to cover adults under age 65 (who are not pregnant and not already covered) with incomes up to 133% of the federal poverty level ("FPL"). *Id.* § 1396a(a)(10)(A)(i)(VIII). This is a significant change, because previously the Medicaid Act did not set a baseline income level for mandatory eligibility. Thus, many states currently

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[59] The plan shall submit claims for reimbursement to HHS, and HHS shall reimburse the plan for 80% of the costs of claims in excess of $15,000 but not greater than $90,000. 42 U.S.C. § 18002(c)(2). The reimbursements will be available until January 1, 2014. *Id.* § 8002(a)(1). This federally-subsidized temporary program closes the gap between now and 2014, when the Exchanges, with their federal tax credits and subsidies, become operational.

do not provide Medicaid to childless adults and cover parents only at much lower income levels.

(2) States will be required to provide Medicaid to all children whose families earn up to 133% of the FPL, including children currently covered through separate CHIP programs. *Id.* §§ 1396a(a)(10)(A)(i)(VII), 1396a(l)(1)(D), 1396a(l)(2)(C). States currently must provide Medicaid to children under age 6 with family income up to 133% of the FPL and children ages 6 through 18 with family income up to 100% of the FPL. *Id.* §§ 1396a(a)(10)(A)(i)(IV), (VI), (VII), 1396a(l)(1)(B)–(D), 1396a(l)(2)(A)–(C).

(3) States are required to at least maintain existing Medicaid eligibility levels for adults and children (that were in place as of March 23, 2010) until a state's Exchange is fully operational. *Id.* § 1396a(gg)(1). Whereas states previously had the option to raise or lower their eligibility levels, states cannot institute more restrictive eligibility standards until the new policies take place. *Id.*

(4) Children under age 26 who were receiving Medicaid but were "aged out" of foster care will be newly eligible to continue receiving Medicaid. *Id.* § 1396a(a)(10)(A)(i)(IX) (effective Jan. 1, 2014).

(5) The new law will increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rates for 2013 and 2014. *Id.* § 1396a(a)(13)(C). States will receive 100% federal funding for the cost of the

increasing payment rates for 2013 and 2014.[60] *Id.* § 1396d(dd).

Having covered the Act's five major components, we examine the two components challenged as unconstitutional: (1) the Medicaid expansion and (2) the individual mandate.

III. CONSTITUTIONALITY OF MEDICAID EXPANSION

The state plaintiffs challenge the district court's grant of summary judgment in favor of the government on the state plaintiffs' claim that the Act's expansion of the Medicaid program, enacted pursuant to the Spending Clause, is unduly coercive under *South Dakota v. Dole*, 483 U.S. 203, 211, 107 S. Ct. 2793, 2798 (1987). For the reasons given below, we conclude that it is not.

A. History of the Medicaid Program

Medicaid is a long-standing partnership between the national and state sovereigns that has been in place for nearly half a century. "In 1965, Congress enacted the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, as Title XIX of the Social Security Act." *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1232 (11th Cir. 2011); *see also Harris v. McRae*, 448 U.S. 297, 301, 100 S. Ct. 2671, 2680 (1980). "Medicaid is a jointly financed federal-state cooperative program, designed to help states furnish medical treatment to their needy citizens." *Reese*, 637 F.3d at 1232. The Medicaid Act "prescribes substantive requirements governing the scope of each state's program." *Curtis v. Taylor*, 625 F.2d 645, 649 (5th Cir. 1980).[61] "Section 1396a provides that a 'State plan for medical assistance' must meet various guidelines, including the provision of certain categories of care and services." *Reese*, 637 F.3d at 1232 (citing 42 U.S.C. § 1396a). "Some of these categories are discretionary, while others are mandatory for participating states." *Id.* (citing 42 U.S.C. § 1396a(a)(10)).

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[60] *See also* Julie Stone, *et al.*, Cong. Research Serv., R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in the PPACA* 2–4 (2010).

Under the Act, the Medicaid program serves as a cornerstone for expanded health care coverage. As explained above in Section II(H), the Act expands Medicaid eligibility and provides significant Medicaid subsidies to the impoverished. As a result of the Act's Medicaid expansion, an estimated 9 million of the 50 million uninsured will be covered for health care by 2014 (and 16 million by 2016 and 17 million by 2021).[62]

The federal government will pay 100% of the fees associated with the increased Medicaid eligibility and subsidies beginning in 2014 and until 2016; that percentage will then drop gradually each year until reaching 90% in 2020. 42 U.S.C. § 1396d(y)(1). The federal government will not cover administrative expenses associated with implementing the new Medicaid policies. *See id.* Under 42 U.S.C. § 1396c, a state whose plan does not comply with the requirements under § 1396a will be notified by HHS of its noncompliance, and "further payments will not be made to the State (or, in [HHS's] discretion . . . payments will be limited to categories under or parts of the State plan not affected by such failure), until [HHS] is satisfied that there will no longer be any such failure to comply." *Id.* § 1396c.

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[61] In *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc), this Court adopted as binding precedent all decisions of the former Fifth Circuit issued before the close of business on September 30, 1981

[62] CBO, *Analysis*, *supra* note 15, at 18 tbl.3.

B. Congress's Power under the Spending Clause

The Spending Clause provides that "Congress shall have Power . . . to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. CONST. art. I, § 8, cl. 1. The Spending Clause permits Congress to "fix the terms on which it shall disburse federal money to the States." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 101 S. Ct. 1531, 1539 (1981). "[L]egislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." *Id.* at 17, 101 S. Ct. at 1540.

There are four primary restrictions on legislation enacted pursuant to the Spending Clause. First, the exercise of the spending power must be in pursuit of the general welfare. *See Helvering v. Davis*, 301 U.S. 619, 640, 57 S. Ct. 904, 908 (1937). Second, the conditions on the receipt of federal funds must be reasonably related to the legislation's stated goal. *Dole*, 483 U.S. at 207, 107 S. Ct. at 2796. Third, Congress's intent to condition funds on a particular action must be unambiguous and must enable the states to knowingly exercise their choice whether to participate. *Pennhurst*, 451 U.S. at 17, 101 S. Ct. at 1540. Finally, the federal legislation cannot "induce the States to engage in activities that would themselves be unconstitutional." *Dole*, 483 U.S. at 210, 107 S. Ct. at 2798. The state plaintiffs do not contend the Act's Medicaid expansion violates any of these restrictions.[63]

Rather, the state plaintiffs argue that the Medicaid expansion violates an additional limitation on the use of the spending power to encourage state legislation, one that derives not from the spending power alone, but also from the Tenth Amendment's reservation of certain powers to the states. U.S. CONST. amend. X; *see Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 585, 57 S. Ct. 883, 890 (1937); *West Virginia v. HHS*, 289 F.3d 281, 286–87 (4th Cir. 2002). Congress may not employ the spending power in such a way as to "coerce" the states into compliance with the federal objective. *See Dole*, 483 U.S. at 211, 107 S. Ct. at 2798; *Steward Mach.*, 301 U.S. at 589–91, 57 S. Ct. at 892–93; *cf. Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687, 119 S. Ct. 2219, 2231 (1999) (holding that a state's waiver of its sovereign immunity is not voluntary where Congress has made it a condition of the state's participation in an otherwise lawful activity). This restriction is different from the restrictions stemming from the spending power because it addresses whether the legislation, while perhaps an appropriate use of the spending power, goes beyond the Spending Clause by forcing the states to participate in a federal program. *Cf. Printz v. United States*, 521 U.S. 898, 117 S. Ct. 2365 (1997) (holding that Congress may not enact a law pursuant to one of its enumerated powers and then compel state officers to execute those federal laws); *see also Steward Mach.*, 301 U.S. at 585, 57 S. Ct. at 890. That is, the coercion test asks whether the federal scheme removes state choice and compels the state to act because the state, in fact, has no other option.

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[63] The state plaintiffs suggest that the conditions imposed here violated the second Dole restriction because they have no reasonable relationship to the size of the federal inducement. States' Opening Br. at 48, 53. In so arguing, the plaintiffs misinterpret *Dole*. The Supreme Court made clear that the required relationship is between the conditions imposed and "the federal interest in particular national projects or programs," *Dole*, 483 U.S. at 207, 107 S. Ct. at 2796 (quotation marks omitted)—that is, "the purpose of federal spending." *New York v. United States*, 505 U.S. 144, 167, 122 S. Ct. 2408, 2423 (1992). The state plaintiffs mistakenly assert that the required relationship is between the conditions imposed and "the size of the federal inducement." States' Opening Br. at 53. The condition Congress imposes here on the receipt of federal funds—requiring Medicaid coverage of certain newly eligible individuals—is undeniably related to the purpose of the Medicaid Act, which is to "provid[e] federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *McRae*, 448 U.S. at 301, 100 S. Ct. at 2680.

The coercion doctrine was first discussed at length by the Supreme Court in *Charles C. Steward Machine Co. v. Davis*. In that case, a corporation challenged the imposition of an employment tax under the newly enacted Social Security Act.

Addressing the corporation's argument that the federal government improperly coerced states into participation in the Social Security program, the Supreme Court stated:

> The difficulty with the petitioner's contention is that it confuses motive with coercion. Every tax is in some measure regulatory. To some extent it interposes an economic impediment to the activity taxed as compared with others not taxed. In like manner every rebate from a tax when conditioned upon conduct is in some measure a temptation. But to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties. The outcome of such a doctrine is the acceptance of a philosophical determinism by which choice becomes impossible. Till now the law has been guided by a robust common sense which assumes the freedom of the will as a working hypothesis in the solution of its problems. . . . Nothing in the case suggests the exertion of a power akin to undue influence, *if we assume that such a concept can ever be applied with fitness to the relations between state and nation*. Even on that assumption the location of the point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, of fact.

301 U.S. at 589–90, 57 S. Ct. at 892 (quotation marks and citation omitted) (emphasis added).

This discussion of the coercion doctrine was later revived by the Supreme Court in *South Dakota v. Dole*. In *Dole*, the state of South Dakota challenged 23 U.S.C. § 158, which directed the Secretary of

Transportation to withhold a percentage of federal highway funds otherwise allocable to the states if states failed to maintain a minimum drinking-age requirement of 21 years. 483 U.S. at 205, 107 S. Ct. at 2795. The Court noted that Congress may attach conditions on the receipt of federal funds to meet certain policy objectives, including those that Congress could not otherwise meet through direct regulation. *Id.* at 206–07, 107 S. Ct. at 2795–96. After analyzing whether the minimum drinking-age condition met the four restrictions on the Spending Clause discussed above, the Court noted, "Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* at 211, 107 S. Ct. at 2798 (quoting *Steward Mach.*, 301 U.S. at 590, 57 S. Ct. at 892). It further opined:

> When we consider, for a moment, that all South Dakota would lose if she adheres to her chosen course as to a suitable minimum drinking age is 5% of the funds otherwise obtainable under specified highway grant programs, the argument as to coercion is shown to be more rhetoric than fact. . . .
>
> Here Congress has offered relatively mild encouragement to the States to enact higher minimum drinking ages than they would otherwise choose. But the enactment of such laws remains the prerogative of the States *not merely in theory but in fact.*

Id. (emphasis added). Thus, the Court once again recognized the coercion doctrine, but found no violation.

The limited case law on the doctrine of coercion and the fact that the Supreme Court has never devised a test to apply it has left many circuits with the conclusion that the doctrine, twice recognized by the Supreme Court, is not a viable defense to Spending Clause legislation. *See, e.g., Pace v. Bogalusa City Sch. Bd.*, 403 F.3d 272, 278 (5th Cir. 2005) (en banc) ("It goes without saying that, because states have the independent power to lay and collect taxes, they retain the ability to avoid the imposition of unwanted federal regulation simply by rejecting federal funds."); *A.W. v. Jersey City Pub. Schs.*, 341 F.3d 234, 243–44 (3d Cir. 2003) (noting that the state's freedom to tax makes it difficult to find a federal law coercive, even when that law threatens to withhold all federal funding in a particular area); *Kansas v. United States*, 214 F.3d 1196, 1201–02 (10th Cir. 2000) ("The cursory statements in *Steward Machine* and *Dole* mark the extent of the Supreme Court's discussion of a coercion theory. The Court has never employed the theory to invalidate a funding condition, and federal courts have been similarly reluctant to use it." (footnote omitted)); *id.* at 1202 (observing that the theory is "unclear, suspect, and has little precedent to support its application"); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (noting in a Medicaid expansion case that "to the extent that there is any viability left in the coercion theory, it is not reflected in the facts of this record"); *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989) ("The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments."); *Oklahoma v. Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981) ("The courts are not suited to evaluating whether the states are faced here with an offer they cannot refuse or merely a hard choice. . . . We therefore follow the lead of other courts that have explicitly declined to enter this thicket when similar funding conditions have been at issue.") (pre-*Dole*); *N.H. Dep't of Emp't Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980) ("Petitioners argue, however, that this option of the state to refuse to participate in the program is illusory, since the severe financial consequences that would follow such refusal negate any real choice. . . . We do not agree that the carrot has become a club because rewards for conforming have increased. It is not the size of the stakes that controls, but the rules of the game.") (pre-*Dole*).

Even in those circuits that do recognize the coercion doctrine, it has had little success. *See West Virginia v. HHS*, 289 F.3d at 290, 294–95 (rejecting a coercion doctrine challenge to previous Medicaid Act amendments on the ground that the Secretary may choose to withhold only some funds); *Jim C. v. United States*, 235 F.3d 1079, 1081–82 (8th Cir. 2000) (en banc) (holding that loss of all federal education funds, in that case amounting to 12% of the state's education budget, was "politically painful" but not coercive). Indeed, our review of the relevant case law indicates that no court has ever struck down a law such as this one as unduly coercive.

There are two cases in which the Supreme Court has struck down a statute because it violated the Tenth Amendment's prohibition on commandeering state legislators and executive officials to perform the federal government's work. While not Spending Clause cases, these cases do give us an understanding of when a law may be considered so coercive as to violate the Tenth Amendment. In *New York v. United States*, the Court struck down as unduly coercive a portion of the Low-Level Radioactive Waste Policy Amendments Act that required states to "take title" to waste created within the state, noting that Congress has ample opportunity to create incentives for states to act the way that Congress desires. 505 U.S. 144, 176–77, 112 S. Ct. 2408, 2428–29 (1992); *see also Printz*, 521 U.S. 898, 117 S. Ct. 2365 (holding, in accord with *New York*, that Congress cannot compel states to enact or administer federal regulatory programs).[64] It is clear from these two cases that Congress cannot directly compel a state to act, nor can Congress hinge the state's right to regulate in an area that the state has a constitutional right to regulate on the state's participation in a federal program. Either act is clearly unconstitutionally coercive.

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[64] The Supreme Court has also briefly discussed coercion in another context. In *Florida Prepaid*, the Court held that federal courts lack jurisdiction over a Lanham Act suit against a state, despite a law purporting to abrogate the states' sovereign immunity under the Lanham Act. 527 U.S. at 691, 119 S. Ct. at 2233. While the holding rested on Eleventh Amendment immunity grounds, Justice Scalia noted: "[W]e think where the constitutionally guaranteed protection of the States' sovereign immunity is involved, the point of coercion is automatically passed—and the voluntariness of waiver destroyed—when what is attached to the refusal to waive is the exclusion of the State from otherwise lawful activity." *Id.* at 687, 119 S. Ct. at 2231.

If anything can be said of the coercion doctrine in the Spending Clause context, however, it is that it is an amorphous one, honest in theory but complicated in application. But this does not mean that we can cast aside our duty to apply it; indeed, it is a mystery to us why so many of our sister circuits have done so. To say that the coercion doctrine is not viable or does not exist is to ignore Supreme Court precedent, an exercise this Court will not do. As the district court noted, "The reluctance of some circuits to deal with this issue because of the potential legal and factual complexities is not entitled to a great deal of weight, because courts deal every day with the difficult complexities of applying Constitutional principles set forth and defined by the Supreme Court." *Florida ex rel. McCollum v. HHS*, 716 F. Supp. 2d 1120, 1160 (N.D. Fla. 2010).[65] If the government is correct that Congress *should* be able to place any and all conditions it wants on the money it gives to the states, then the Supreme Court must be the one to say it.

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[65] In *Florida ex rel. McCollum v. HHS*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010), the district court granted in part and denied in part the government's motion to dismiss. In *Florida ex rel. Bondi v. HHS*, No. 3:10-CV-91-RV/EMT, __ F. Supp. 2d __, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011), the district court ruled that (1) the Medicaid expansion did not exceed Congress's Spending Clause powers and (2) the individual mandate is beyond Congress's commerce powers and is inseverable from the rest of the Act.

For now, we find it a reasonable conclusion that *Dole* instructs that the Tenth Amendment places certain limitations on congressional spending; namely, that Congress cannot place restrictions so burdensome and threaten the loss of funds so great and important to the state's integral function as a state—funds that the state has come to rely on heavily as part of its everyday service to its citizens—as to compel the state to participate in the "optional" legislation. This is the point where "'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211, 107 S. Ct. at 2798 (quoting *Steward Mach.*, 301 U.S. at 590, 57 S. Ct. at 892).

And so it is not without serious thought and some hesitation that we conclude that the Act's expansion of Medicaid is not unduly coercive under *Dole* and *Steward Machine*. There are several factors, which, for us, are determinative. First, the Medicaid-participating states were warned from the beginning of the Medicaid program that Congress reserved the right to make changes to the program. *See* 42 U.S.C. § 1304 ("The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress."); *McRae*, 448 U.S. at 301, 100 S. Ct. at 2680 (noting "[a]lthough participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements" that Congress sees fit to impose). Indeed, Congress has made numerous amendments to the program since its inception in 1965. 42 U.S.C. § 1396a Note (listing amendments).[66] In each of these previous amendments, the states were given the option to comply with the changes, or lose all or part of their funding. *Id.* § 1396c. None of these amendments has been struck down as unduly coercive.

Second, the federal government will bear nearly all of the costs associated with the expansion. The states will only have to pay incidental administrative costs associated with the expansion until 2016; after which, they will bear an increasing percentage of the cost, capping at 10% in 2020.[67] *Id.*

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[66] The government discusses the various Medicaid expansions at length:

> Congress has amended the Medicaid Act many times since its inception, and between 1966 and 2000, Medicaid enrollment increased from four million to 33 million recipients. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 106 (Fall 2000). For example, in 1972, Congress required participating states to extend Medicaid to recipients of Supplemental Security Income, thereby significantly expanding Medicaid enrollment. Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972). In 1989, Congress again expanded enrollment by requiring states to extend Medicaid to pregnant women and children under age six who meet certain income limits. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989).

Government's Reply Br. at 46–47.

[67] At oral argument, the state plaintiffs expressed a concern that Medicaid costs would be even larger because the individual mandate would greatly increase the number of

§ 1396d(y)(1). If states bear little of the cost of expansion, the idea that states are being coerced into spending money in an ever-growing program seems to us to be "more rhetoric than fact." *Dole*, 483 U.S. at 211, 107 S. Ct. at 2798.

Third, states have plenty of notice—nearly four years from the date the bill was signed into law—to decide whether they will continue to participate in Medicaid by adopting the expansions or not. This gives states the opportunity to develop new budgets (indeed, Congress allocated the cost of the entire expansion to the federal government initially, with the cost slowly shifting to the states over a period of six years) to deal with the expansion, or to develop a replacement program in their own states if they decide to do so. Fourth, like our sister circuits, we cannot ignore the fact that the states have the power to tax and raise revenue, and therefore can create and fund programs of their own if they do not like Congress's terms. *See Pace*, 403 F.3d at 278; *Jersey City Pub. Schs.*, 341 F.3d at 243–44.

Finally, we note that while the state plaintiffs vociferously argue that states who choose not to participate in the expansion will lose all of their Medicaid funding, nothing in the Medicaid Act states that this is a foregone conclusion. Indeed, the

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persons in Medicaid who are currently eligible but for one reason or another do not choose to participate. This argument is not persuasive, however, as to whether the expansions themselves are coercive, because the increase in enrollment would still occur if the mandate were upheld, even if the Medicaid expansions were struck down.

Medicaid Act provides HHS with the discretion to withhold all or merely a portion of funding from a noncompliant state. 42 U.S.C. § 1396c; *see also West Virginia v. HHS*, 289 F.3d at 291–92; *Dole*, 483 U.S. at 211, 107 S. Ct. at 2798 (finding no coercion when "all South Dakota would lose if she adheres to her chosen course as to a suitable minimum drinking age is 5% of the funds otherwise obtainable under specified highway grant programs").

Taken together, these factors convince us that the Medicaid-participating states have a real choice—not just in theory but in fact—to participate in the Act's Medicaid expansion. *See Dole*, 483 U.S. at 211, 107 S. Ct. at 2798. Where an entity has a real choice, there can be no coercion. *See Steward Mach.*, 301 U.S. at 590, 57 S. Ct. at 892 (noting that in the absence of undue influence, "the law has been guided by a robust common sense which assumes the freedom of the will as a working hypothesis in the solution of its problems").

Accordingly, the district court's grant of summary judgment to the government on the Medicaid expansion issue is affirmed.

We now turn to the constitutionality of the Act's fourth component: the individual mandate. We begin with the relevant constitutional clauses and Supreme Court precedent.

IV. SUPREME COURT'S COMMERCE CLAUSE DECISIONS

Two constitutional provisions govern our analysis of whether Congress acted within its commerce authority in enacting the individual mandate: the

Commerce Clause and the Necessary and Proper Clause. U.S. CONST. art. I, § 8, cls. 3, 18.

Seven words in the Commerce Clause—"[t]o regulate Commerce . . . among the several States," *id.* art. I, § 8, cl. 3—have spawned a 200-year debate over the permissible scope of this enumerated power. For many years, the Supreme Court described Congress's commerce power as regulating "traffic"—the "buying and selling, or the interchange of commodities"—and "intercourse" among states, including transportation. *See Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 189–90 (1824). Under this early understanding of the Clause, Congress could not reach commerce that was strictly internal to a state. *See id.* at 194–95 ("The enumeration presupposes something not enumerated; and that something, if we regard the language or the subject of the sentence, must be the exclusively internal commerce of a State.").

Ultimately, in recognition of a modern and integrated national economy and society, the New Deal decisions of the Supreme Court charted an expansive doctrinal path. *See, e.g.*, *United States v. Darby*, 312 U.S. 100, 61 S. Ct. 451 (1941); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 57 S. Ct. 615 (1937). These Supreme Court decisions adopted a broad view of the Commerce Clause, in tandem with the Necessary and Proper Clause, and permitted Congress to regulate purely local, intrastate economic activities that substantially affect interstate commerce. The "substantial effects" doctrine, along with the related "aggregation" doctrine, expanded the reach of Congress's commerce power exponentially. Nonetheless, the Supreme

Court has staunchly maintained that the commerce power contains outer limits which are necessary to preserve the federal-state balance in the Constitution.

We therefore review the principal Commerce Clause precedents that inform our analysis of the difficult question before us. Although extensive, this survey is necessary to understanding the rudiments of the Supreme Court's existing Commerce Clause doctrines that we, as an inferior Article III court, must apply.

A. *Wickard v. Filburn*

One of the early "substantial effects" decisions is *Wickard v. Filburn*, 317 U.S. 111, 63 S. Ct. 82 (1942), where the Supreme Court held that Congress's wheat production quotas were constitutional as applied to a plaintiff farmer's home-grown and home-consumed wheat. The Agricultural Adjustment Act of 1938 ("AAA") sought to control the volume of wheat in interstate and foreign commerce by placing acreage limits on farmers. *Id.* at 115, 63 S. Ct. at 84. This scheme was intended to prevent wheat surpluses and shortages, attendant price instability, and obstructions to commerce. *Id.*

Plaintiff Filburn operated a small farm raising wheat. *Id.* at 114, 63 S. Ct. at 84. Filburn sold some of this wheat crop, allocated a portion as feed for livestock and poultry on his farm, used another portion as flour for home consumption, and preserved the remainder for future seedings. *Id.* Although his AAA allotment was only 11.1 acres, Filburn sowed and harvested 23 acres of wheat—

11.9 excess acres that the Supreme Court treated as home-consumed wheat.[68] *Id.* at 114–15, 63 S. Ct. at 84. This violation subjected him to a penalty of 49 cents a bushel.[69] *Id.* Filburn sued, claiming that Congress's acreage quotas on his home-consumed wheat exceeded its commerce power because the regulated activities were local in nature and their effects upon interstate commerce were "indirect." *Id.* at 119, 63 S. Ct. at 86.

The Supreme Court examined the factors of home-consumed wheat that impinged on interstate commerce—factors which could potentially frustrate Congress's regulatory scheme if not controlled. The Court declared that home-consumed wheat "constitutes the most variable factor in the disappearance of the wheat crop," since "[c]onsumption on the farm where grown appears to vary in an amount greater than 20 per cent of average production." *Id.* at 127, 63 S. Ct. at 90. Filburn's home-consumed wheat therefore "compete[d]" with wheat sold in commerce, since "it supplies a need of the man who grew it which would otherwise be reflected by purchases in the open market." *Id.* at 128, 63 S. Ct. at 91.

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[68] *See also Gonzales v. Raich*, 545 U.S. 1, 20, 125 S. Ct. 2195, 2207 (2005) (noting that *Wickard* Court treated Filburn's wheat as home-consumed, not part of commercial farming operation).

[69] These penalties were levied regardless of "whether any part of the wheat either within or without the quota, is sold or intended to be sold." *Wickard*, 317 U.S. at 119, 63 S. Ct. at 86.

The *Wickard* Court recognized that "the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices" and "it can hardly be denied that a factor of such volume and variability as home-consumed wheat would have a substantial influence on price and market conditions." *Id.* at 128, 63 S. Ct. at 90–91. Therefore, the objectives of the AAA acreage quotas—"to increase the market price of wheat and to that end to limit the volume thereof that could affect the market"—constituted appropriate regulatory goals. *Id.*

Despite the fact that Congress's commerce power "has been held to have great latitude," *id.* at 120, 63 S. Ct. at 86, the Supreme Court recognized the novelty of its decision, remarking that "there is no decision of this Court that such activities may be regulated where no part of the product is intended for interstate commerce or intermingled with the subjects thereof." *Id.* at 120, 63 S. Ct. at 86–87. However, the *Wickard* Court concluded that "even if [Filburn's] activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce and this irrespective of whether such effect is what might at some earlier time have been defined as 'direct' or 'indirect.'" *Id.* at 125, 63 S. Ct. at 89. The Court declared that "questions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect' and foreclose consideration of the actual effects of the activity in question upon interstate commerce." *Id.* at 120, 63 S. Ct. at 87; *see also id.* at 123–24, 63 S. Ct. at 88 (stating that "the relevance of the economic effects in the application of the Commerce Clause . . . has made the mechanical application of legal formulas no longer feasible").

Even though Filburn's own contribution to wheat demand "may be trivial by itself," this was "not enough to remove him from the scope of federal regulation where, as here, his contribution, taken together with that of many others similarly situated, is far from trivial." *Id.* at 127–28, 63 S. Ct. at 90. Since Filburn's homegrown wheat slackened demand for market-based wheat and placed downward pressures on price, "Congress may properly have considered that wheat consumed on the farm where grown if wholly outside the scheme of regulation would have a substantial effect in defeating and obstructing its purpose to stimulate trade therein at increased prices." *Id.* at 128–29, 63 S. Ct. at 91.

The Supreme Court noted that restricting Filburn's acreage could have the effect of forcing Filburn to buy wheat in the market: "It is said, however, that this Act, forcing some farmers into the market to buy what they could provide for themselves, is an unfair promotion of the markets and prices of specializing wheat growers." *Id.* at 129, 63 S. Ct. at 91. Rejecting this, the Supreme Court stated, "It is of the essence of regulation that it lays a restraining hand on the self-interest of the regulated and that advantages from the regulation commonly fall to others." *Id.*

B. *United States v. South-Eastern Underwriters Association*

Although not concerning the "substantial effects" doctrine, the 1944 case *United States v. South-Eastern Underwriters Association*, 322 U.S. 533, 64 S. Ct. 1162 (1944), is important to our analysis, as it marked the Supreme Court's first recognition that the insurance business *is commerce*—and where it is conducted across state borders, it constitutes interstate commerce capable of being regulated by Congress.[70] *Id.* at 553, 64 S. Ct. at 1173. The Supreme Court emphasized the interstate character of insurance business practices, which resulted in a "continuous and indivisible stream of intercourse among the states composed of collections of premiums, payments of policy obligations, and the countless documents and communications which are essential to the negotiation and execution of policy contracts." *Id.* at 541, 64 S. Ct. at 1167. The defendants' insurances policies "covered not only all kinds of fixed local properties, but also . . . movable goods of all types carried in interstate and foreign commerce by every media of transportation." *Id.* at 542, 64 S. Ct. at 1168.

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[70] Prior to 1944, the Supreme Court consistently upheld the power of the states to regulate insurance. During those early years, Congress had not regulated insurance, but the states had. The operative question concerned whether Congress's power to regulate interstate commerce deprived states of the power to regulate the insurance business themselves. Since Congress had not sought to regulate insurance, an invalidation of the states' statutes would entail that insurance companies could operate without any regulation. The earlier Supreme Court decisions held that insurance is not commerce, thereby skirting any constitutional problem arising from the Constitution's grant of power to Congress to regulate interstate commerce. *See Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868); *see also N.Y. Life Ins. Co. v. Deer Lodge Cnty.*, 231 U.S. 495, 34 S. Ct. 167 (1913); *Hooper v. California*, 155 U.S. 648, 15 S. Ct. 207 (1895).

The *South-Eastern Underwriters* Court rejected the notion that, if any components of the insurance business constitute interstate commerce, the states may not exercise regulatory control over the industry. *Id.* at 548, 64 S. Ct. at 1171. Nevertheless, the Court pronounced that "[n]o commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance." *Id.* at 553, 64 S. Ct. at 1173.

C. *Heart of Atlanta Motel v. United States*

In another landmark Commerce Clause case, *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 85 S. Ct. 348 (1964), the Supreme Court held that Congress acted within its commerce authority in enacting Title II of the Civil Rights Act of 1964, which prohibited discrimination in public accommodations. The plaintiff owned and operated a 216-room motel whose guests were primarily out-of-state visitors. *Id.* at 243, 85 S. Ct. at 350–51. The motel refused to rent rooms to black patrons. *Id.* at 243, 85 S. Ct. at 351.

The Supreme Court detailed the "overwhelming evidence that discrimination by hotels and motels impedes interstate travel." *Id.* at 253, 85 S. Ct. at

355. The Court noted that it had "long been settled" that transportation of persons in interstate commerce is within Congress's regulatory power, regardless of "whether the transportation is commercial in character." *Id.* at 256, 85 S. Ct. at 357. Additionally, Supreme Court precedents confirmed that "the power of Congress to promote interstate commerce also includes the power to regulate the local incidents thereof . . . which might have a substantial and harmful effect upon that commerce." *Id.* at 258, 85 S. Ct. at 358. Thus, "Congress may—as it has—prohibit racial discrimination by motels serving travelers, however 'local' their operations may appear." *Id.*

The *Heart of Atlanta Motel Court* acknowledged that "Congress could have pursued other methods to eliminate the obstructions it found in interstate commerce caused by racial discrimination," but the means employed in removing such obstructions are "within the sound and exclusive discretion of the Congress" and are "subject only to one caveat—that the means chosen by it must be reasonably adapted to the end permitted by the Constitution." *Id.* at 261–62, 85 S. Ct. at 360. The means chosen by Congress in Title II clearly met this standard.[71]

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[71] In *Katzenbach v. McClung*, 379 U.S. 294, 85 S. Ct. 377 (1964), a companion case, the Court also upheld Title II's prohibition on discrimination in restaurants serving food to interstate travelers or serving food that had moved in interstate commerce.

D. *United States v. Lopez*

For the next thirty years, the Supreme Court applied an expansive interpretation of Congress's commerce power and upheld a wide variety of statutes. *See, e.g., Preseault v. ICC*, 494 U.S. 1, 110 S. Ct. 914 (1990) (upholding statute amending National Trails System Act in facial challenge); *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 101 S. Ct. 2352 (1981) (sustaining Surface Mining Control and Reclamation Act in facial challenge); *Perez v. United States*, 402 U.S. 146, 91 S. Ct. 1357 (1971) (sustaining Title II of Consumer Credit Protection Act in as-applied challenge); *Maryland v. Wirtz*, 392 U.S. 183, 88 S. Ct. 2017 (1968) (upholding validity of amendments to Fair Labor Standards Act of 1938 in facial challenge), *overruled on other grounds, Nat'l League of Cities v. Usery*, 426 U.S. 833, 96 S. Ct. 2465 (1976), *overruled by Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 105 S. Ct. 1005 (1985). These cases reflect a practical need to allow federal regulation of a growing and unified national economy.

In 1995, the Supreme Court decided *United States v. Lopez*, 514 U.S. 549, 115 S. Ct. 1624 (1995), the first Supreme Court decision since the 1930s to rule that Congress had exceeded its commerce power. *Lopez* concerned the Gun-Free School Zones Act of 1990, which made it a federal offense "for any individual knowingly to possess a firearm at a place that the individual knows, or has reasonable cause to believe, is a school zone." 18 U.S.C. § 922(q)(1)(A) (1993). The defendant Alfonso Lopez, a twelfth-grade student, was convicted of carrying a concealed handgun to his Texas school. *Lopez*, 514 U.S. at 551, 115 S. Ct. at 1626.

In a 5–4 opinion, the *Lopez* Court invalidated § 922(q). The *Lopez* Court first observed that the Constitution created a federal government of enumerated, delegated, and thus limited powers. *Id.* at 552, 115 S. Ct. at 1626. Although the Supreme Court's New Deal precedents expanded Congress's commerce power, the *Lopez* Court recognized that "this power is subject to outer limits." *Id.* at 557, 115 S. Ct. at 1628. The *Lopez* Court then enumerated the "three broad categories of activity that Congress may regulate under its commerce power": (1) "the use of the channels of interstate commerce"; (2) "the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities"; and (3) "those activities that substantially affect interstate commerce."[72] *Id.* at 558–59, 115 S. Ct. at 1629–30. After determining that § 922(q) could be sustained only under this third category, the *Lopez* Court identified four factors influencing its analysis of whether gun possession in school zones substantially affects interstate commerce.

First, the *Lopez* Court differentiated between economic and non-economic activity, stressing how prior cases utilizing the substantial effects test to reach intrastate conduct had all involved economic activity. The Supreme Court stated that "Section 922(q) is a criminal statute that by its terms has nothing to do with 'commerce' or any sort of economic enterprise" and was "not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Id.* at 561, 115 S. Ct. at 1630–31. The Court opined that "[e]ven *Wickard*, which is perhaps the most far reaching example of Commerce Clause authority over intrastate activity, involved *economic activity* in a way that the possession of a gun in a school zone does not." *Id.* at 560, 115 S. Ct. at 1630 (emphasis added). The *Lopez* Court acknowledged that "a determination whether an intrastate activity is commercial or noncommercial may in some cases result in legal uncertainty," yet "so long as [Congress's] enumerated powers are interpreted as having judicially enforceable outer limits, congressional legislation under the Commerce Clause always will engender 'legal uncertainty.'" *Id.* at 566, 115 S. Ct. at 1633.

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[72] The "third *Lopez* prong is the broadest expression of Congress' commerce power." *United States v. Ballinger*, 395 F.3d 1218, 1226 (11th Cir. 2005) (en banc).

Second, the *Lopez* Court found it significant that § 922(q) did not contain a "jurisdictional element" to "ensure, through case-by-case inquiry, that the firearm possession in question affects interstate commerce." *Id.* at 561, 115 S. Ct. at 1631. Instead, the Act penalized "mere possession" and lacked any requirement that there be "an explicit connection with or effect on interstate commerce."[73] *Id.* at 562, 115 S. Ct. at 1631.

Third, the Court noted that Congress provided no legislative findings demonstrating the purported nexus between gun possession around schools and its effects on interstate commerce. *Id.* at 562–63, 115 S. Ct. at 1631–32.

Fourth, the *Lopez* Court examined the actual relationship between gun possession in a school zone and its effects on interstate commerce. The government posited three effects: (1) violent crime, even when purely local, generates substantial costs that are spread to the wider populace through insurance; (2) individuals are deterred from traveling to areas beset by violent crime; and (3) guns in schools imperil the learning environment, which in turn adversely impacts national productivity. *Id.* at 563–64, 115 S. Ct. at 1632.

The *Lopez* Court declared that the government's arguments yielded no limiting principles. For example, under the government's proffered "costs of crime" theory, "Congress could regulate not only all violent crime, but all activities that might lead to violent crime, regardless of how tenuously they relate to interstate commerce." *Id.* at 564, 115 S. Ct. at 1632. Likewise, the "national productivity" rationale afforded no bounds, either. If Congress could employ its Commerce Clause authority to "regulate activities that adversely affect the learning environment, then, *a fortiori*, it also can regulate the educational process directly." *Id.* at 566, 115 S. Ct. at 1633. Indeed, "Congress could regulate any activity that it found was related to the economic productivity of individual citizens," including "marriage, divorce, and child custody." *Id.* at 564, 115 S. Ct. at 1632.

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[73] In this respect, the *Lopez* Court contrasted the Gun-Free School Zones Act of 1990 with the firearm possession statute at issue in *United States v. Bass*, 404 U.S. 336, 92 S. Ct. 515 (1971). In *Bass*, the Supreme Court construed legislation making it a federal crime for a felon to "receiv[e], posses[s], or transpor[t] *in commerce or affecting commerce* . . . any firearm." *Lopez*, 514 U.S. at 561–62, 115 S. Ct. at 1631 (emphasis added) (quoting former 18 U.S.C. § 1202(a)). The *Lopez* Court stated that "[u]nlike the statute in Bass, § 922(q) has no express jurisdictional element which might limit its reach to a discrete set of firearm possessions that additionally have an explicit connection with or effect on interstate commerce." *Id.* at 562, 115 S. Ct. at 1631.

The Supreme Court pronounced that these links were too attenuated to conclude that the regulated activity "substantially affects" interstate commerce: "[I]f we were to accept the Government's arguments, we are hard pressed to posit any activity by an individual that Congress is without power to regulate." *Id.* "To uphold the Government's contentions," the Supreme Court continued, "we would have to pile inference upon inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States." *Id.* at 567, 115 S. Ct. at 1634.

Lastly, the *Lopez* Court acknowledged that some of the Supreme Court's precedents gave "great deference to congressional action" but refused to expand the "broad language" of these precedents any further, since "[t]o do so would require us to conclude that the Constitution's enumeration of powers does not presuppose something not enumerated." *Id.* Such judicial abdication would dissolve the "distinction between what is truly national and what is truly local" and subvert constitutional notions of federalism. *Id.* at 567–68, 115 S. Ct. at 1634.

Although both joined the majority opinion in full, two justices wrote separately and echoed the majority's emphasis on the significance of the federal-state balance in the structure of the Constitution, and the need for judicial intervention when Congress has "tipped the scales too far." *See id.* at 568–83, 115 S. Ct. at 1634–42 (Kennedy, J., concurring);[74] *id.* at 584–602, 115 S. Ct. at 1642–51 (Thomas, J., concurring).[75]

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[74] In a concurring opinion, Justice Kennedy explained why he joined the *Lopez* majority opinion in full and what he characterized as its "necessary though limited holding." 514 U.S. at 568, 115 S. Ct. at 1634 (Kennedy, J., concurring). Justice Kennedy noted "the imprecision of content-based boundaries used without more to define the limits of the Commerce Clause," referring to earlier dichotomies that distinguished between "manufacturing and commerce," "direct and indirect effects," and other formalistic categories. *Id.* at 574, 115 S. Ct. at 1637. He stressed that the Supreme Court is "often called upon to resolve questions of constitutional law not susceptible to the mechanical application of bright and clear lines." *Id.* at 579, 115 S. Ct. at 1640.

Justice Kennedy found that § 922(q) "upsets the federal balance to a degree that renders it an unconstitutional assertion of the commerce power, and our intervention is required." *Id.* at 580, 115 S. Ct. at 1640. Much like the majority opinion, Justice Kennedy emphasized the far-reaching implications of the government's position: "In a sense any

E. *United States v. Morrison*

In another 5–4 decision, the Supreme Court in *United States v. Morrison*, 529 U.S. 598, 120 S. Ct. 1740 (2000), reapplied the *Lopez* principles and invalidated a section of the Violence Against Women Act of 1994 ("VAWA"), 42 U.S.C. § 13981, which provided a federal civil remedy for victims of gender-motivated violence.[76]

In enacting the VAWA, Congress made specific findings about the relationship between gender-motivated violence and its substantial effects on interstate commerce. Congress declared its objectives were "to protect victims of gender motivated violence" and "to promote public safety,

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conduct in this interdependent world of ours has an ultimate commercial origin or consequence, but we have not yet said the commerce power may reach so far. If Congress attempts that extension, then at the least we must inquire whether the exercise of national power seeks to intrude upon an area of traditional state concern." *Id.* Such an interference was present in *Lopez*, as "it is well established that education is a traditional concern of the States." *Id.* Justice Kennedy added that courts have a "duty to recognize meaningful limits on the commerce power of Congress." *Id.*

[75] *See* discussion of Justice Thomas's concurring opinion *infra* note 78.

[76] The VAWA provided that a person who "commits a crime of violence motivated by gender . . . shall be liable to the party injured, in an action for the recovery of compensatory and punitive damages, injunctive and declaratory relief, and such other relief as a court may deem appropriate." 42 U.S.C. § 13981(c).

health, and activities affecting interstate commerce."[77] *Id.* § 13981(a).

The *Morrison* Court observed that since the New Deal case of *Jones & Laughlin Steel*, "Congress has had considerably greater latitude in regulating conduct and transactions under the Commerce Clause than our previous case law permitted." *Morrison*, 529 U.S. at 608, 120 S. Ct. at 1748. *Lopez* clarified, however, that "Congress' regulatory authority is not without effective bounds." *Id.*

The Supreme Court stated that "a fair reading of *Lopez* shows that the noneconomic, criminal nature of the conduct at issue was central to our decision in that case." *Id.* at 610, 120 S. Ct. at 1750. The *Morrison* Court pointed out that "[g]ender-motivated crimes of violence are not, in any sense of the phrase, economic activity." *Id.* at 613, 120 S. Ct. at 1751. "While we need not adopt a categorical rule against aggregating the effects of any noneconomic activity in order to decide these cases," the Supreme Court reiterated that "our cases have upheld Commerce Clause regulation of intrastate activity only where that activity is economic in nature." *Id.*

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[77] The *Morrison* plaintiff was a college student allegedly raped by two football players. 529 U.S. at 602, 120 S. Ct. at 1745–46. The plaintiff filed suit in federal court under § 13981(c). *Id.* at 604, 120 S. Ct. at 1746. The defendant's motion to dismiss argued that Congress lacked authority to enact the VAWA's federal civil remedy provision under either the Commerce Clause or § 5 of the Fourteenth Amendment. *Id.* at 604, 120 S. Ct. at 1746–47.

The Supreme Court next noted that § 13981 contained no jurisdictional element. It commented that another provision of the VAWA, which similarly provided a federal remedy for gender-motivated crime, *did* contain a jurisdictional hook. *Id.* at 613 n.5, 120 S. Ct. at 1752 n.5 (discussing 18 U.S.C. § 2261(a)(1), which at the time applied only to an individual "who travels across a State line or enters or leaves Indian country").

Unlike § 922(q) in *Lopez*, § 13981 was "supported by numerous findings regarding the serious impact that gender-motivated violence has on victims and their families." *Id.* at 614, 120 S. Ct. at 1752. Nonetheless, the *Morrison* Court stated that congressional findings were not dispositive, echoing *Lopez's* statement that "[s]imply because Congress may conclude that a particular activity substantially affects interstate commerce does not necessarily make it so." *Id.* (alteration in original) (quoting *Lopez*, 514 U.S. at 557 n.2, 115 S. Ct. at 1624 n.2).

The *Morrison* Court determined that "Congress' findings are substantially weakened by the fact that they rely so heavily on a method of reasoning that we have already rejected as unworkable if we are to maintain the Constitution's enumeration of powers." *Id.* at 615, 120 S. Ct. at 1752. The congressional findings in *Morrison* asserted that gender-motivated violence deterred potential victims from interstate travel and employment in interstate business, decreased national productivity, and increased medical costs. *Id.* According to the *Morrison* Court, "[t]he reasoning that petitioners advance seeks to follow the but-for causal chain from the initial occurrence of violent crime (the suppression of which has always been the prime object of the States' police power) to every attenuated effect upon interstate commerce." *Id.* The logical entailment of this "but-for causal chain" of reasoning "would allow Congress to regulate any crime as long as the nationwide, aggregated impact of that crime has substantial effects on employment, production, transit, or consumption." *Id.* at 615, 120 S. Ct. at 1752–53. Such arguments suggested no stopping point, and Congress could thereby exercise powers traditionally reposed in the states.[78] *Id.* at 615–16, 120 S. Ct. at 1753.

F. *Gonzales v. Raich*

Next came *Gonzales v. Raich*, 545 U.S. 1, 125 S. Ct. 2195 (2005), where the Supreme Court, in a 6–3 vote, concluded that Congress acted within its commerce power in prohibiting the plaintiffs' wholly intrastate production and possession of marijuana, even though California state law approved the drug's use for medical purposes. The legislation at issue was the Controlled Substances Act ("CSA"), 21 U.S.C. § 801 *et seq.*, in which Congress sought to "conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances" and "prevent the diversion of drugs from legitimate to illicit channels." *Raich*, 545 U.S. at 12–13, 125 S. Ct. at 2203. Congress consequently "devised a closed regulatory system making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except in a manner authorized by the CSA." *Id.* at 13, 125 S. Ct. at 2203. Under the CSA, marijuana is classified as a "Schedule I" drug, meaning that the manufacture, distribution, or possession of marijuana constitutes a criminal offense. *Id.* at 14, 125 S. Ct. at 2204.

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[78] Although joining the majority opinion in full in both *Lopez* and *Morrison*, Justice Thomas wrote separately in both cases to reject the substantial effects doctrine. In *Morrison*, Justice Thomas wrote "only to express my view that the very notion of a 'substantial effects' test under the Commerce Clause is inconsistent with the original understanding of Congress' powers and with this Court's early Commerce Clause cases." 529 U.S. at 627, 120 S. Ct. at 1759 (Thomas, J., concurring). Characterizing the substantial effects test as a "rootless and malleable standard," Justice Thomas remarked that the Supreme Court's present Commerce Clause jurisprudence had encouraged the federal government to operate under the misguided belief that the Clause "has virtually no limits." *Id.* Unless the Supreme Court reversed its course," we will continue to see Congress appropriating state police powers under the guise of regulating commerce." *Id.*

In 1996, California voters passed Proposition 215, which exempted from criminal prosecution physicians who recommend marijuana to a patient for medical purposes, as well as patients and primary caregivers who possess and cultivate marijuana for doctor-approved medical purposes.[79] *Id.* at 5–6, 125 S. Ct. at 2199. The two California plaintiffs, Angel Raich and Diane Monson, suffered from serious medical conditions and used marijuana as medication for several years, as recommended by their physicians. *Id.* at 6–7, 125 S. Ct. at 2199–2200. Monson cultivated her own marijuana, while Raich relied upon two caregivers to provide her with locally grown marijuana at no cost. *Id.* at 7, 125 S. Ct. at 2200.

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[79] Proposition 215 is codified as the Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5.

After federal agents seized and destroyed Monson's cannabis plants, the *Raich* plaintiffs sued. *Id.* They acknowledged that the CSA was within Congress's commerce authority and did not contend that any section of the CSA was unconstitutional. *Id.* at 15, 125 S. Ct. at 2204. Instead, they argued solely that the CSA was unconstitutional *as applied to* their manufacture, possession, and consumption of cannabis for personal medical use. *Id.* at 7–8, 125 S. Ct. at 2200.

In rejecting the plaintiffs' "quite limited" as-applied challenge, the *Raich* Court stated that its case law "firmly establishes Congress' power to regulate purely local activities that are part of an economic 'class of activities' that have a substantial effect on interstate commerce." *Id.* at 15, 17, 125 S. Ct. at 2204–05. The Supreme Court emphasized that, in assessing Congress's commerce power, its review was a "modest one": "We need not determine whether respondents' activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Id.* at 22, 125 S. Ct. at 2208. The *Raich* Court commented that "[w]hen Congress decides that the 'total incidence' of a practice poses a threat to a national market, it may regulate the entire class," and it need not "legislate with scientific exactitude." *Id.* at 17, 125 S. Ct. at 2206 (quotation marks omitted). "[W]e have reiterated," the Supreme Court continued, "that when 'a general regulatory statute bears a substantial relation to commerce, the *de minimis* character of individual instances arising under that statute is of no consequence.'" *Id.* (quotation marks omitted) (quoting *Lopez*, 514 U.S. at 558, 115 S. Ct. at 1629).

The Supreme Court found similar regulatory concerns underlying both the CSA in *Raich* and the AAA wheat provisions in *Wickard*. Just as rising market prices could draw wheat grown for home consumption into the interstate market and depress prices, a "parallel concern making it appropriate to include marijuana grown for home consumption in the CSA is the likelihood that the high demand in the interstate market will draw such marijuana into that market." *Id.* at 19, 125 S. Ct. at 2207. In both cases, there was a threat of unwanted commodity diversion that could disrupt Congress's regulatory control over interstate commerce. *Id.*

According to the *Raich* Court, *Wickard* established that "Congress can regulate purely intrastate activity that is not itself 'commercial,' in that it is not produced for sale, if it concludes that failure to regulate that class of activity would undercut the regulation of the interstate market in that commodity." *Id.* at 18, 125 S. Ct. at 2206. Characterizing the similarities between the plaintiffs' case and *Wickard* as "striking," the *Raich* Court explained that "[i]n both cases, the regulation is squarely within Congress' commerce power because production of the commodity meant for home consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity." *Id.* at 18–19, 125 S. Ct. at 2206–07.

The *Raich* Court opined that the failure to regulate intrastate production and possession of marijuana would leave a "gaping hole" in the CSA's regulatory scheme: CSA enforcement would be frustrated by the difficulty in distinguishing between locally cultivated marijuana and out-of-state marijuana, and the marijuana authorized by state law could be diverted into "illicit channels." *Id.* at 22, 125 S. Ct. at 2209. The *Raich* Court rejected the notion that California had "surgically excised a discrete activity that is hermetically sealed off from the larger interstate marijuana market." *Id.* at 30, 125 S. Ct. at 2213. Accordingly, even though the CSA "ensnares some purely intrastate activity," the *Raich* Court "refuse[d] to excise individual components of that larger scheme." *Id.* Instead, "congressional judgment that an exemption for such a significant segment of the total market would undermine the orderly enforcement of the entire regulatory scheme is entitled to a strong presumption of validity." *Id.* at 28, 125 S. Ct. at 2212.

The *Raich* Court concluded that the statutory challenges in *Lopez* and *Morrison* were "markedly different" from the plaintiffs' statutory challenge to the CSA. *Id.* at 23, 125 S. Ct. at 2209. Whereas the *Raich* plaintiffs sought to "excise individual applications of a concededly valid statutory scheme," the Supreme Court noted that "in both *Lopez* and *Morrison*, the parties asserted that a particular statute or provision fell outside Congress' commerce power in its entirety." *Id.* The *Raich* Court considered this distinction between facial and as-applied challenges "pivotal" because "[w]here the class of activities is regulated and that class is within the reach of federal power, the courts have no power to excise, as trivial, individual instances of the class." *Id.* (alteration in original) (quoting *Perez*, 402 U.S. at 154, 91 S. Ct. at 1361). Additionally, since the CSA was a "lengthy and detailed statute creating a comprehensive framework," its statutory scheme was "at the opposite end of the regulatory spectrum" from the statutes in *Lopez* and *Morrison*. *Id.* at 24, 125 S. Ct. at 2210.

Once again central to the Court's analysis was whether the regulated activities were economic or noneconomic. The *Raich* Court defined "[e]conomics" as referring to "the production, distribution, and consumption of commodities." *Id.* at 25–26, 125 S. Ct. at 2211 (quoting WEBSTER'S THIRD NEW INT'L DICTIONARY 720 (1966)). In contrast to the activities regulated in *Lopez* and *Morrison*, the *Raich* Court concluded that "the activities regulated by the CSA are quintessentially economic." *Id.* at 25, 125 S. Ct. at 2211. Indeed, the activities engaged in by the plaintiffs themselves fit the Court's definition of economic, since they involved the production, distribution, and consumption of marijuana.

Concurring in only the *Raich* judgment, Justice Scalia commented that under his understanding of the commerce power, "the authority to enact laws necessary and proper for the regulation of interstate commerce is not limited to laws governing intrastate activities that substantially affect interstate commerce. Where necessary to make a regulation of interstate commerce effective, Congress may regulate even those intrastate activities that do not themselves substantially affect interstate commerce." *Id.* at 34–35, 125 S. Ct. at 2216 (Scalia, J., concurring).

Justice Scalia cited "two general circumstances" in which the regulation of intrastate activities may be "necessary to and proper for the regulation of interstate commerce." *Id.* at 35, 125 S. Ct. at 2216. First, "the commerce power permits Congress not only to devise rules for the governance of commerce between States but also to facilitate interstate commerce by eliminating potential obstructions, and to restrict it by eliminating potential stimulants." *Id.* at 35, 125 S. Ct. at 2216. Yet, "[t]his principle is not without limitation," as the cases of *Lopez* and *Morrison* made clear. *Id.* at 35–36, 125 S. Ct. at 2216–17. Second, Justice Scalia submitted that "Congress may regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce." *Id.* at 37, 125 S. Ct. at 2217. The "relevant question" then becomes "whether the means chosen are 'reasonably adapted' to the attainment of a legitimate end under the commerce power." *Id.*

In addition to relying on these Commerce Clause cases, both parties and the district court conducted a separate analysis of the Necessary and Proper Clause's implications for the Act. We review some foundational principles relating to that Clause, focusing our attention on *United States v. Comstock*, 560 U.S. __, 130 S. Ct. 1949 (2010).

G. Necessary and Proper Clause: *United States v. Comstock*

Congress has the power "[t]o make all Laws which shall be necessary and proper for carrying into

Execution" its enumerated power. U.S. CONST. art. I, § 8, cl. 18. The Necessary and Proper Clause is intimately tied to the enumerated power it effectuates. The Supreme Court has recognized that the Necessary and Proper Clause "is not the delegation of a new and independent power, but simply provision for making effective the powers theretofore mentioned." *Kansas v. Colorado*, 206 U.S. 46, 88, 27 S. Ct. 655, 663 (1907). It is "merely a declaration, for the removal of all uncertainty, that the means of carrying into execution those [powers] otherwise granted are included in the grant." *Kinsella v. United States*, 361 U.S. 234, 247, 80 S. Ct. 297, 304 (1960) (alterations in original) (quoting VI WRITINGS OF JAMES MADISON 383 (Gaillard Hunt ed., 1906)). It reaffirms that Congress has the incidental powers necessary to carry its enumerated powers into effect.

The Supreme Court's most definitive statement of the Necessary and Proper Clause's function remains Chief Justice Marshall's articulation in *McCulloch v. Maryland*: "Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional." 17 U.S. (4 Wheat.) 316, 421 (1819). Thus, when legislating within its enumerated powers, Congress has broad authority: "the Necessary and Proper Clause makes clear that the Constitution's grants of specific federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive' to the authority's 'beneficial exercise.'" *Comstock*, 560

U.S. at __, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 413, 418).

As it relates to the commerce power, the Supreme Court has essentially bound up the Necessary and Proper Clause with its substantial effects analysis.[80]

As Justice Scalia noted in *Raich*, "Congress's regulatory authority over intrastate activities that are not themselves part of interstate commerce (including activities that have a substantial effect on interstate commerce) derives from the Necessary and Proper Clause." 545 U.S. at 34, 125 S. Ct. at 2216 (Scalia, J., concurring).

Comstock represents the Supreme Court's most recent, detailed application of Necessary and Proper Clause doctrine. In *Comstock*, the Supreme Court held that Congress acted pursuant to its Article I powers in enacting a federal civil-commitment statute, 18 U.S.C. § 4248, that authorized the Department of Justice to detain mentally ill, sexually dangerous prisoners beyond the term of their sentences. The majority opinion enumerated five "considerations" that supported the statute's constitutional validity: "(1) the breadth of the Necessary and Proper Clause, (2) the long history of federal involvement in this arena, (3) the sound reasons for the statute's enactment in light of the Government's custodial interest in safeguarding the public from dangers posed by those in federal custody, (4) the statute's accommodation of state interests, and (5) the statute's narrow scope." *Comstock*, 560 U.S. at __, 130 S. Ct. at 1965.

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[80] For instance, the Court formulated the question in *Raich* as "whether the power vested in Congress by Article I, § 8, of the Constitution 'to make all Laws which shall be necessary and proper for carrying into Execution' its authority to 'regulate Commerce with foreign Nations, and among the several States' includes the power [asserted]." 545 U.S. at 5, 125 S. Ct. at 2198–99 (alteration omitted). Although the *Wickard* Court did not expressly invoke the Necessary and Proper Clause, the *Raich* Court clearly assumed as much. *See id.* at 22, 125 S. Ct. at 2209.

On the breadth of the Necessary and Proper Clause, the *Comstock* Court noted that (1) the federal government is a government of enumerated powers, but (2) is also vested "'with ample means'" for the execution of those powers. *Id.* (quoting *McCulloch*, 17 U.S. at 408). The Supreme Court must determine whether a federal statute "constitutes a means that is rationally related to the implementation of a constitutionally enumerated power." *Id.* "[T]he relevant inquiry is simply 'whether the means chosen are reasonably adapted to the attainment of a legitimate end under the commerce power' or under other powers that the Constitution grants Congress the authority to implement." *Id.* at __, 130 S. Ct. at 1957 (quotation marks omitted) (quoting *Raich*, 545 U.S. at 37, 125 S. Ct. at 2217 (Scalia, J., concurring)).

Turning to the second factor—the history of federal involvement—the Supreme Court recognized that, beginning in 1855, persons charged with or convicted of federal offenses could be confined to a federal mental institution for the duration of their sentences. *Id.* at __, 130 S. Ct. at 1959. Since 1949, Congress had also "authorized the postsentence detention of federal prisoners who suffer from a mental illness and who are thereby dangerous." *Id.* at __, 130 S. Ct. at 1961. The Supreme Court observed that "[a]side from its specific focus on sexually dangerous persons, § 4248 is similar to the provisions first enacted in 1949" and therefore represented "a modest addition to a longstanding federal statutory framework, which has been in place since 1855." *Id.*

As to the third factor—reasons for enactment in light of the government's interest—the Supreme Court concluded that "Congress reasonably extended its longstanding civil-commitment system to cover mentally ill and sexually dangerous persons who are already in federal custody, even if doing so detains them beyond the termination of their criminal sentence." *Id.* The federal government: (1) is the custodian of its prisoners and (2) has the power to protect the public from the threats posed by the prisoners in its charge. *Id.*

Turning to the fourth factor—accommodation of state interests—the *Comstock* Court ruled that § 4248 "properly accounts for state interests." *Id.* at __, 130 S. Ct. at 1962. The Supreme Court found persuasive that the statute required the Attorney General (1) to allow (and indeed encourage) the state in which the prisoner was domiciled or tried to take custody and (2) to immediately release the prisoner if the state seeks to assert authority over him.[81] *Id.*

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[81] The Attorney General must "make all reasonable efforts to cause" the state in which the prisoner is domiciled or tried to "assume responsibility for his custody, care, and treatment." *Comstock*, 560 U.S. at __, 130 S. Ct. at 1954 (quoting 18 U.S.C.

On the fifth and final factor—the statute's narrow scope—the Comstock Court found the statute not "too sweeping in its scope" and the link between § 4248 and an enumerated Article I power "not too attenuated." *Id.* at __, 130 S. Ct. at 1963. The Supreme Court concluded that *Lopez's* admonition that courts should not "pile inference upon inference" did not present any problems with respect to the civil-commitment statute. *Id.* (quoting *Lopez*, 514 U.S. at 567, 115 S. Ct. at 1634). Specifically, the *Comstock Court* discerned that "the same enumerated power that justifies the creation of a federal criminal statute, and that justifies the additional implied federal powers that the dissent considers legitimate, justifies civil commitment under § 4248 as well." *Id.* at __, 130 S. Ct. at 1964. The Supreme Court rejected the notion that "Congress's authority can be no more than one step removed from a specifically enumerated power." *Id.* at __, 130 S. Ct. at 1963.

Lastly, the Supreme Court emphasized that § 4248 had been applied to "only a small fraction of federal prisoners." *Id.* at __, 130 S. Ct. at 1964 (citing evidence that "105 individuals have been subject to § 4248 out of over 188,000 federal inmates"). The Supreme Court concluded that "§ 4248 is a reasonably adapted and narrowly tailored means of pursuing the Government's legitimate interest as a federal custodian in the responsible administration of its prison system" and thus did not endow Congress with a general police power. *Id.* at __, 130 S. Ct. at 1965.

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§ 4248(d)). If the state consents, the prisoner will be released to the appropriate official in that state. *Id.* at __, 130 S. Ct. at 1954–55. If the state declines to take custody, the Attorney General will "place the person for treatment in a suitable facility" until the state assumes the role or until the person no longer poses a sexually dangerous threat. *Id.* at __, 130 S. Ct. at 1955 (quoting 18 U.S.C. § 4248(d)).

Although concurring in the judgment, Justice Kennedy and Justice Alito[82] did not join the Court's majority opinion. Because Justice Kennedy's concurring opinion focuses on Commerce Clause and federalism issues, we provide extended treatment of it here.

Justice Kennedy's primary disagreement with the majority concerned its application of a "means-ends rationality" test. He advised that "[t]he terms 'rationally related' and 'rational basis' must be employed with care, particularly if either is to be used as a stand-alone test." *Id.* at __, 130 S. Ct. at 1966 (Kennedy, J., concurring). Justice Kennedy observed that the phrase "rational basis" is typically employed in Due Process Clause contexts, where the Court adopts a very deferential review of congressional acts. *Id.* Under the *Lee Optical* test applied in such due process settings, the Court merely asks whether "'it might be thought that the particular legislative measure was a rational way to correct'" an evil. *Id.* (quoting *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 487–88, 75 S. Ct. 461, 464 (1955)). By contrast, Justice Kennedy asserted, "under the Necessary and Proper Clause, application of a 'rational basis' test should be at least as exacting as it has been in the Commerce Clause cases, if not more so." *Id.*

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[82] Justice Alito wrote separately to express "concern[] about the breadth of the Court's language, and the ambiguity of the standard that the Court applies." 560 U.S. at __, 130 S. Ct. at1968 (Alito, J., concurring) (citation omitted). Justice Alito stressed that "the Necessary and Proper Clause does not give Congress *carte blanche*." *Id.* at __, 130 S. Ct. at 1970. While theword "necessary" need not connote that the means employed by Congress be "absolutely necessary" or "indispensable," "the term requires an 'appropriate' link between a power conferred by the Constitution and the law enacted by Congress." *Id.* It is the Supreme Court's duty, he declared, "to enforce compliance with that limitation." *Id.* Like Justice Kennedy, Justice Alito suggested that the Necessary and Proper Clause context of the case did not warrant an analysis "in which it is merely possible for a court to think of a rational basis on which Congress might have perceived an attenuated link between the powers underlying the federal criminal statutes and the challenged civil commitment provision." *Id.* In *Comstock*, by contrast, the government had demonstrated "a substantial link to Congress' constitutional powers." *Id.*

The Commerce Clause precedents of *Raich*, *Lopez*, and *Hodel* "require a tangible link to commerce, not a mere conceivable rational relation, as in *Lee Optical*." *Id.* at __, 130 S. Ct. at 1967. "The rational basis referred to in the Commerce Clause context is a demonstrated link in fact, based on empirical demonstration." *Id.* Justice Kennedy reiterated *Lopez*'s admonition that "'[s]imply because Congress may conclude that a particular activity substantially affects interstate commerce does not necessarily make it so.'" *Id.* (quoting *Lopez*, 514 U.S. at 557 n.2, 115 S. Ct. at 1629 n.2). In this regard, "[w]hen the inquiry is whether a federal law has sufficient links to an enumerated power to be within the scope of federal authority, the analysis depends not on the number of links in the congressional-power chain but on the strength of the chain." *Id.* at __, 130 S. Ct. at 1966.

In summary, these landmark Supreme Court decisions—*Wickard, South- Eastern Underwriters, Heart of Atlanta Motel, Lopez, Morrison, Raich*, and *Comstock*—together set forth the governing principles and analytical framework we must apply to the commerce power issues presented here.

V. CONSTITUTIONALITY OF INDIVIDUAL MANDATE UNDER THE COMMERCE POWER

With a firm understanding of the Act's provisions, the congressional findings, and the Supreme Court's Commerce Clause precedents, we turn to the central question at hand: whether the individual mandate is beyond the constitutional power granted to Congress under the Commerce Clause and Necessary and Proper Clause.

In this Section, we begin with first principles. We then examine the subject matter the individual mandate seeks to regulate, and whether it can be readily categorized under the classes of activity the Supreme Court has previously identified. We follow with a discussion of the unprecedented nature of the individual mandate. Next, we analyze whether the individual mandate is a valid exercise of Congress's power to regulate activities that substantially affect interstate commerce. In this regard, we appraise whether the government's argument furnishes judicially enforceable limiting principles and address the individual mandate's far-reaching implications for our federalist structure. Lastly, we consider the government's alternative argument that the individual mandate is an essential part of a larger regulation of economic activity.

We conclude that the individual mandate exceeds Congress's commerce power.

A. First Principles

As the Supreme Court has observed, "The judicial authority to determine the constitutionality of laws, in cases and controversies, is based on the premise that the 'powers of the legislature are defined and limited; and that those limits may not be mistaken, or forgotten, the constitution is written.'" *City of Boerne v. Flores*, 521 U.S. 507, 516, 117 S. Ct. 2157, 2162 (1997) (quoting *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 176 (1803)). The judiciary is called upon not only to interpret the laws, but at times to enforce the Constitution's limits on the power of Congress, even when that power is used to address an intractable problem.

In enforcing these limits, we recognize that the Constitution established a federal government that is "'acknowledged by all to be one of enumerated powers.'" *Comstock*, 560 U.S. at __, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 405). In describing this constitutional structure, the Supreme Court has emphasized James Madison's exposition in The Federalist No. 45: "'The powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite.'" *Gregory v. Ashcroft*, 501 U.S. 452, 458, 111 S. Ct. 2395, 2399 (1991) (quoting THE FEDERALIST NO. 45, at 292–93 (James Madison)

(Clinton Rossiter ed., 1961)); *see also Lopez*, 514 U.S. at 552, 115 S. Ct. at 1626 (quoting same). In that same essay, Madison noted that the commerce power was one such enumerated power: "The regulation of commerce, it is true, is a new power; but that seems to be an addition which few oppose, and from which no apprehensions are entertained." THE FEDERALIST NO. 45, at 289 (James Madison) (E.H. Scott ed., 1898). The commerce power has since come to dominate federal legislation.

The power to regulate commerce is the power "to prescribe the rule by which commerce is to be governed." *Gibbons*, 22 U.S. at 196. As the Supreme Court instructs us, "The power of Congress in this field is broad and sweeping; where it keeps within its sphere and violates no express constitutional limitation it has been the rule of this Court, going back almost to the founding days of the Republic, not to interfere." *Katzenbach v. McClung*, 379 U.S. 294, 305, 85 S. Ct. 377, 384 (1964). In fact, if the object of congressional legislation falls within the sphere contemplated by the Commerce Clause, "[t]hat power is plenary and may be exerted to protect interstate commerce no matter what the source of the dangers which threaten it." *Jones & Laughlin Steel Corp.*, 301 U.S. at 37, 57 S. Ct. at 624 (citation and quotation marks omitted).

It is because of the breadth and depth of this power that even when the Supreme Court has blessed Congress's most expansive invocations of the Commerce Clause, it has done so with a word of warning: "Undoubtedly the scope of this power must be considered in the light of our dual system of government and may not be extended so as to embrace effects upon interstate commerce so indirect and remote that to embrace them, in view of our complex society, would effectually obliterate the distinction between what is national and what is local and create a completely centralized government." *Id.* It is this dualistic nature of the Commerce Clause power—necessarily broad yet potentially dangerous to the fundamental structure of our government—that has led the Court to adopt a flexible approach to its application, one that is often difficult to apply. As Chief Justice Hughes noted,

> Whatever terminology is used, the criterion is necessarily one of degree and must be so defined. This does not satisfy those [who] seek for mathematical or rigid formulas. But such formulas are not provided by the great concepts of the Constitution such as 'interstate commerce,' 'due process,' 'equal protection.' In maintaining the balance of the constitutional grants and limitations, it is inevitable that we should define their applications in the gradual process of inclusion and exclusion.

Santa Cruz Fruit Packing Co. v. NLRB., 303 U.S. 453, 467, 58 S. Ct. 656, 660 (1938); *see also Lopez*, 514 U.S. at 566, 115 S. Ct. at 1633 ("But, so long as Congress' authority is limited to those powers enumerated in the Constitution, and so long as those enumerated powers are interpreted as having judicially enforceable outer limits, congressional legislation under the Commerce Clause always will engender 'legal uncertainty.'").

Thus, it is not surprising that *Lopez* begins not with categories or substantial effects tests, but rather "first principles," reaffirming the "constitutionally mandated division of authority [that] 'was adopted by the Framers to ensure protection of our fundamental liberties.'" 514 U.S. at 553, 115 S. Ct. at 1626 (citing *Gregory*, 501 U.S. at 458, 111 S. Ct. at 2400). While the substantial growth and development of Congress's power under the Commerce Clause has been well-documented, the Court has often reiterated that the power therein granted remains "subject to outer limits." *Id.* at 557, 115 S. Ct. at 1628. When Congress oversteps those outer limits, the Constitution requires judicial engagement, not judicial abdication.

The Supreme Court has placed two broad limitations on congressional power under the Commerce Clause. First, Congress's regulation must accommodate the Constitution's federalist structure and preserve "a distinction between what is truly national and what is truly local." *Id.* at 567–68, 115 S. Ct. at 1634. Second, the Court has repeatedly warned that courts may not interpret the Commerce Clause in a way that would grant to Congress a general police power, "which the Founders denied the National Government and reposed in the States." *Morrison*, 529 U.S. at 618, 120 S. Ct. at 1754; *see also Lopez*, 514 U.S. at 584, 115 S. Ct. at 1642 (Thomas, J., concurring) ("[W]e *always* have rejected readings of the Commerce Clause and the scope of federal power that would permit Congress to exercise a police power; our cases are quite clear that there are real limits to federal power.").

Therefore, in determining if a congressional action is within the limits of the Commerce Clause, we must look not only to the action itself but also its implications for our constitutional structure. *See Lopez*, 514 U.S. at 563–68, 115 S. Ct. at 1632–34. While these structural limitations are often discussed in terms of federalism, their ultimate goal is the protection of individual liberty. *See Bond v. United States*, 564 U.S. __, __, 131 S. Ct. 2355, 2363 (2011) ("Federalism secures the freedom of the individual."); *New York v. United States*, 505 U.S. at 181, 112 S. Ct. at 2431 ("The Constitution does not protect the sovereignty of States for the benefit of the States or state governments as abstract political entities .... To the contrary, the Constitution divides authority between federal and state governments for the protection of individuals.").

With this at stake, we examine whether Congress legislated within its constitutional boundaries in enacting the individual mandate.[83] We begin this analysis with a "presumption of constitutionality," meaning that "we invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds." *Morrison*, 529 U.S. at 607, 120 S. Ct. at 1748.

B. Dichotomies and Nomenclature

The parties contend that the answer to the question of the individual mandate's constitutionality is straightforward. The government emphasizes that Congress intended to regulate the health insurance and health care markets to ameliorate the cost-shifting problem created by individuals who forego insurance yet at some time in the future seek health care for which they cannot pay. 42 U.S.C. § 18091(a)(1)(A), (H). One of the tools Congress employed to solve that problem is an economic mandate requiring Americans to purchase and continuously maintain health insurance. The government argues that the individual mandate is constitutional because it regulates "quintessentially economic" activity related to an industry of near universal participation, whereas the regulations in *Lopez* and *Morrison* touched on criminal conduct, which is not "in any sense of the phrase, economic activity." *Morrison*, 529 U.S. at 613, 120 S. Ct. at 1751. The government submits that Congress has mandated only how Americans finance their inevitable health care needs.

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[83] As a preliminary matter, we note that the parties appear to agree that if the individual mandate is to be sustained, it must be under the third category of activities that Congress may regulate under its commerce power: *i.e.*, "those activities that substantially affect interstate commerce." *Lopez*, 514 U.S. at 559, 115 S. Ct. at 1630.

The plaintiffs respond that the plain text of the Constitution and Supreme Court precedent support the conclusion that "activity" is a prerequisite to valid congressional regulation under the commerce power. The plaintiffs stress that Congress's authority is to "regulate" commerce, not to compel individuals to *enter into* commerce so that the federal government may regulate them. The plaintiffs point out that by choosing not to purchase insurance, the uninsured are outside the stream of commerce. Indeed, the nature of the conduct is marked by the *absence* of a commercial transaction. Since they are not engaged in commerce, or activities associated with commerce, they cannot be regulated pursuant to the Commerce Clause. The plaintiffs emphasize that, in 220 years of constitutional history, Congress has never exercised its commerce power in this manner.

Whereas the parties and many commentators have focused on this distinction between activity and inactivity, we find it useful only to a point. Beginning with the plain language of the text, the Commerce Clause gives Congress the power to "regulate Commerce." U.S. CONST. art. I, § 8, cl. 3. The power to regulate commerce, of course, presupposes that something exists to regulate. In its first comprehensive discussion of the Commerce Clause, the Supreme Court in Gibbons attempted to define commerce, stating, "Commerce, undoubtedly, is traffic, but it is something more: it is *intercourse*. It describes the commercial intercourse between nations, and parts of nations, in all its branches, and *is regulated by prescribing rules for carrying on that intercourse.*" *Gibbons*, 22 U.S. at 189–90 (emphasis added). The nature of Chief Justice Marshall's formulation presaged the Supreme Court's tendency to describe commerce in very general terms, since an attempt to formulate a precise and all-encompassing definition would prove impractical.

However, the Supreme Court has always described the commerce power as operating on already existing or ongoing activity. The *Gibbons* Court stated, "If Congress has the power to regulate it, that power must be exercised whenever the subject *exists*. If it exists within the States, if a foreign voyage may commence or terminate at a port within a State, then the power of Congress may be exercised within a State." *Id.* at 195 (emphasis added). In its recent cases, the Supreme Court has continued to articulate Congress's commerce authority in terms of "activity." In *Lopez*, the Court identified "three broad *categories of activity* that Congress may regulate under its commerce power" and concluded that "possession of a gun in a local school zone is in no sense an *economic activity*." 514 U.S. at 558, 567, 115 S. Ct. at 1629, 1634 (emphasis added); *see also Raich*, 545 U.S. at 26, 125 S. Ct. at 2211 ("[T]he CSA is a statute that directly regulates *economic, commercial activity*." (emphasis added)); *Morrison*, 529 U.S. at 611, 120 S. Ct. at 1750 ("*Lopez*'s review of Commerce Clause case law demonstrates that in those cases where we have sustained federal regulation of intrastate *activity* based upon the *activity's* substantial effects on interstate commerce, the activity in question has been some sort of *economic endeavor*." (emphasis added)).

As our extensive discussion of the Supreme Court's precedent reveals, Commerce Clause cases run the gamut of possible regulation. But the diverse fact patterns of *Wickard, South-Eastern Underwriters, Heart of Atlanta Motel, Lopez, Morrison*, and *Raich* share at least one commonality: they all involved attempts by Congress to regulate preexisting, freely chosen classes of activities.

Nevertheless, we are not persuaded that the formalistic dichotomy of activity and inactivity provides a workable or persuasive enough answer in this case. Although the Supreme Court's Commerce Clause cases frequently speak in activity-laden terms, the Court has never expressly held that activity is a precondition for Congress's ability to regulate commerce—perhaps, in part, because it has never been faced with the type of regulation at issue here.

We therefore must refine our understanding of the nature of the individual mandate and the subject matter it seeks to regulate. The uninsured have made a decision, either consciously or by default, to direct their financial resources to some other item or need than health insurance. Congress described "the activity" it sought to regulate as "economic and financial *decisions* about how and when health care is paid for, and when health insurance is purchased." 42 U.S.C. § 18091(a)(2)(A) (emphasis added). It deemed such decisions as activity that is "commercial and economic in nature." *Id.* Congress linked the individual mandate to this decision: "In the absence of th[is] requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure . . . ." *Id.*

That Congress casts the individual mandate as regulating economic activity is not surprising. In *Morrison*, the Supreme Court acknowledged that "thus far in our Nation's history our cases have upheld Commerce Clause regulation of intrastate activity only where that activity is economic in nature." 529 U.S. at 613, 120 S. Ct. at 1751. *Raich* confirmed the continued viability of this distinction between economic and noneconomic activity in assessing Congress's commerce authority. *See* 545 U.S. at 25–26, 125 S. Ct. at 2210–11.

The parties here disagree about where the individual mandate falls within this "economic versus noneconomic activity" framework. On one hand, a decision not to purchase insurance and to self-insure for health care is a financial decision that has more of an economic patina than the gun possession in *Lopez* or the gender-motivated violence in *Morrison*. But whether such an economic decision constitutes economic *activity* as previously conceptualized by the Supreme Court is not so clear, nor do we find this sort of categorical thinking particularly helpful in assessing the constitutionality of such an unprecedented congressional action. After all, in choosing not to purchase health insurance, the individuals regulated by the individual mandate are hardly involved in the "production, distribution, and consumption of commodities," which was the broad definition of economics provided by the *Raich* Court.[84] 545 U.S. at 25, 125 S. Ct. at 2211 (citation and quotation marks omitted). Rather, to the extent the uninsured can be said to be "active," their activity consists of the *absence* of such behavior, at least with respect to health insurance.[85] Simply put, the individual mandate cannot be neatly classified under either the "economic activity" or "noneconomic activity" headings.

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[84] The fact that conduct may be said to have economic *effects* does not, by that fact alone, render the conduct "economic activity," at least as defined by the Supreme Court. *Lopez* and *Morrison* make this observation apparent. Even the fact that conduct in some way *relates* to commerce does not, by itself, convert that conduct into economic activity. Indeed, the regulated activity in *Lopez* (firearm possession) directly related to an article of commerce (the firearm being possessed). The Supreme Court has emphasized that the relevant inquiry is the *link* between the regulated activity and its effects on interstate commerce.

[85] The government correctly notes that many of the uninsured do actively consume health care, even though they

This confirms the wisdom in the conclusion that the Court's attempts throughout history to define by "semantic or formalistic categories those activities that were commerce and those that were not" are doomed to fail. *Lopez*, 514 U.S. at 569, 115 S. Ct. at 1635 (Kennedy, J., concurring). *Compare United States v. E.C. Knight Co.*, 156 U.S. 1, 13, 15 S. Ct. 249, 254 (1895) (approving manufacturing-commerce dichotomy), *with Standard Oil Co. v. United States*, 221 U.S. 1, 68–69, 31 S. Ct. 502, 519 (1911) (declaring manufacturing-commerce dichotomy "unsound"). *See also Lopez*, 514 U.S. at 572, 115 S. Ct. at 1636 (Kennedy, J., concurring) (noting "the Court's recognition of the importance of a practical conception of the commerce power"); *Wickard*, 317 U.S. at 120, 63 S. Ct. at 87 (stating that "questions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature such as 'production' and 'indirect'"); *Swift & Co. v. United States*, 196 U.S. 375, 398, 25 S. Ct. 276, 280 (1905) (observing that "commerce among the states is not a technical legal conception, but a practical one, drawn from the course of business"). Yet, confusing though these dichotomies and doctrinal vacillations have been, they appear animated by one overarching goal: to provide courts with meaningful, judicially

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are not participants in the health insurance market. We address this point at length later.

administrable limiting principles by which to assess Congress's exercise of its Commerce Clause power.

Properly formulated, we perceive the question before us to be whether the federal government can issue a mandate that Americans purchase and maintain health insurance from a private company for the entirety of their lives.[86] These types of purchasing decisions are legion. Every day, Americans decide what products to buy, where to invest or save, and how to pay for future contingencies such as their retirement, their children's education, and their health care. The government contends that embedded in the Commerce Clause is the power to override these ordinary decisions and redirect those funds to other purposes. Under this theory, because Americans have money to spend and must inevitably make decisions on where to spend it, the Commerce Clause gives Congress the power to direct and compel an individual's spending in order to further its overarching regulatory goals, such as reducing the number of uninsureds and the amount of uncompensated health care.

In answering whether the federal government may exercise this asserted power to issue a mandate for Americans to purchase health insurance from private companies, we next examine a number of issues: (1) the unprecedented nature of the individual mandate; (2) whether Congress's exercise of its commerce authority affords sufficient and meaningful limiting principles; and (3) the far-reaching implications for our federalist structure.

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[86] Whether one describes the regulated individual's decision as the financing of health care, self-insurance, or risk retention, the congressional mandate is to acquire and continuously maintain health coverage. And unless the person is covered by a government-financed health program, the mandate is to purchase insurance from a private insurer.

C. Unprecedented Nature of the Individual Mandate

Both parties have cited extensively to previous Supreme Court opinions defining the scope of the Commerce Clause. Economic mandates such as the one contained in the Act are so unprecedented, however, that the government has been unable, either in its briefs or at oral argument, to point this Court to Supreme Court precedent that addresses their constitutionality. Nor does our independent review reveal such a precedent.

The Supreme Court has sustained Congress's authority to regulate steamboat traffic, *Gibbons*, 22 U.S. 1; trafficking of lottery tickets across state lines, *The Lottery Case*, 188 U.S. 321, 23 S. Ct. 321 (1903); and carrying a woman across state lines for "immoral purposes," *Hoke v. United States*, 227 U.S. 308, 320, 33 S. Ct. 281, 283 (1913). Through the Commerce Clause, Congress may prevent the interstate transportation of liquor, *United States v. Simpson*, 252 U.S. 465, 40 S. Ct. 364 (1920); punish an automobile thief who crosses state lines, *Brooks v. United States*, 267 U.S. 432, 45 S. Ct. 345 (1925); and prevent diseased herds of cattle from bringing their contagion from Georgia to Florida, *Thornton v. United States*, 271 U.S. 414, 46 S. Ct. 585 (1926).

In the modern era, the Commerce Clause has been used to regulate labor practices, *Jones & Laughlin Steel Corp.*, 301 U.S. 1, 57 S. Ct. 615; impose minimum working conditions, *Darby*, 312 U.S. 100, 61 S. Ct. 451; limit the production of wheat for home consumption, *Wickard*, 317 U.S. 111, 63 S. Ct. 82; regulate the terms of insurance contracts, *South-Eastern Underwriters*, 322 U.S. 533, 64 S. Ct. 1162; prevent discrimination in hotel accommodations, *Heart of Atlanta Motel*, 379 U.S. 241, 85 S. Ct. 348, and restaurant services, *Katzenbach*, 379 U.S. 294, 85 S. Ct. 377; and prevent the home production of marijuana for medical purposes, *Raich*, 545 U.S. 1, 125 S. Ct. 2195. What the Court has never done is interpret the Commerce Clause to allow Congress to dictate the financial decisions of Americans through an economic mandate.

Both the Congressional Budget Office ("CBO") and the Congressional Research Service ("CRS") have commented on the unprecedented nature of the individual mandate. When the idea of an individual mandate to purchase health insurance was first floated in 1994, the CBO stated that a "mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action." SPEC. STUDIES DIV., CONG. BUDGET OFFICE, THE BUDGETARY TREATMENT OF AN INDIVIDUAL MANDATE TO BUY HEALTH INSURANCE 1 (1994) [hereinafter CBO MANDATE MEMO]. The CBO observed that Congress "has never required people to buy any good or service as a condition of lawful residence in the United States," noting that "mandates typically apply to people as parties to economic transactions, rather than as members of society." *Id.* at 1–2. Meanwhile, in reviewing the present legislation in 2009, the CRS warned:

> Despite the breadth of powers that have been exercised under the Commerce Clause, it is unclear whether the clause would provide a solid constitutional foundation for legislation containing a requirement to have health insurance. Whether such a requirement would be constitutional under the Commerce Clause is perhaps the most challenging question posed by such a proposal, as it is a novel issue whether Congress may use this clause to require an individual to purchase a good or a service.

Jennifer Staman & Cynthia Brougher, CONG. RESEARCH SERV., R. 40725, REQUIRING INDIVIDUALS TO OBTAIN HEALTH INSURANCE: A CONSTITUTIONAL ANALYSIS 3 (2009).

The fact that Congress has never before exercised this supposed authority is telling. As the Supreme Court has noted, "the utter lack of statutes imposing obligations on the States' executive (notwithstanding the attractiveness of that course to Congress), suggests an assumed *absence* of such power." *Printz*, 521 U.S. at 907–08, 117 S. Ct. at 2371; *see also Va. Office for Prot. & Advocacy v. Stewart*, 563 U.S. __, __, 131 S. Ct. 1632, 1641 (2011) ("Lack of historical precedent can indicate a constitutional infirmity."); *Alden v. Maine*, 527 U.S. 706, 743–44, 119 S. Ct. 2240, 2261 (1999). Few powers, if any, could be more attractive to Congress than compelling the purchase of certain products. Yet even if we focus on the modern era, when congressional power under the

Commerce Clause has been at its height, Congress still has not asserted this authority. Even in the face of a Great Depression, a World War, a Cold War, recessions, oil shocks, inflation, and unemployment, Congress never sought to require the purchase of wheat or war bonds, force a higher savings rate or greater consumption of American goods, or require every American to purchase a more fuel efficient vehicle. [87] *See Printz*, 521 U.S. at 905, 117 S. Ct. at 2370 ("[I]f . . . earlier Congresses avoided use of this highly attractive power, we would have reason to believe that the power was thought not to exist.").

Traditionally, Congress has sought to encourage commercial activity it favors while discouraging what it does not. This is instructive. Not only have prior congressional actions not asserted the power now claimed, they "contain some indication of precisely the opposite assumption." *Id.* at 910, 117 S. Ct. at 2372. Instead of requiring action, Congress has sought to encourage it. The instances of such encouragement are ubiquitous, but the example of flood insurance provides a particularly relevant illustration of how the individual mandate departs from conventional exercises of congressional power.

In passing the National Flood Insurance Act of 1968, Congress recognized that "from time to time flood disasters have created personal hardships and economic distress which have required unforeseen disaster relief measures and have placed an increasing burden on the Nation's resources." 42 U.S.C. § 4001(a)(1). Despite considerable expenditures on public programs designed to prevent floods, those programs had "not been sufficient to protect adequately against growing exposure to future flood losses." *Id.* § 4001(a)(2). In response to this problem, however, Congress did not require everyone who owns a house in a flood plain to purchase flood insurance. In fact, Congress did not even require anyone who chooses to build a new house in a flood plain to buy insurance. Rather, Congress created a series of incentives designed to encourage voluntary purchase of flood insurance. These incentives included requiring flood insurance before the home owner could receive federal financial assistance or federally regulated loans. *See id.* § 4012a(a), (b)(1).

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[87] Compare the lack of legislation compelling activity to the long history of Congress forbidding activity.

Without an "individual mandate," the flood insurance program has largely been a failure. *See* Bryant J. Spann, Note, *Going Down for the Third Time: Senator Kerry's Reform Bill Could Save the Drowning National Flood Insurance Program,* 28 GA. L. REV. 593, 597 (1994) ("One of the most astounding facts to surface from the Midwestern flood of 1993 was that so few homeowners eligible for flood insurance actually had it. Of the states impacted by the flood, Illinois had the highest percentage of eligible households covered, with 8.7%."). One key reason for this low participation is not surprising. "Disaster relief, as a political issue, is almost invincible. No politician wants to be on record as opposing disaster relief, particularly for his or her own constituents." *Id.* at 602. People living in a flood plain know that even if they do not have insurance, they can count on the virtually guaranteed availability of federal funds.[88] Nevertheless, despite the unpredictability of flooding, the inevitability that floods will strike flood plains, and the cost shifting inherent in uninsured property owners seeking disaster relief funds, Congress has never taken the obvious and expedient step of invoking the power the government now argues it has and forcing all property owners in flood plains to purchase insurance.[89]

Contrast flood insurance with the very few instances of activity in which Congress has compelled Americans to engage solely as a consequence of being citizens living in the United States. Given the attractiveness of the power to compel behavior in order to solve important problems, we find it illuminating that Americans have, historically, been subject only to a limited set of personal mandates: serving on juries, registering for the draft, filing tax returns, and responding to the census. These mandates are in the nature of duties owed to the government attendant to citizenship, and they contain clear foundations in the constitutional text[90]. Additionally, all these mandates involve a citizen directly interacting with the government, whereas the individual mandate requires an individual to enter into a compulsory contract with a private company. In these respects, the individual mandate is a sharp departure from all prior exercises of federal power.

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[88] Compare this with the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, which ensures public access to emergency medical services without regard to one's ability to pay.

[89] The contrast with the individual mandate is even more stark when we consider that property owners in flood plains have actually entered the housing market.

The draft is an excellent example of this sort of duty, particularly as it is one upon which the Supreme Court has spoken. In the *Selective Draft Law Cases*, the Supreme Court reviewed challenges to the draft instituted in 1917 upon the entry of the United States into World War I. 245 U.S. 366, 38 S. Ct. 159 (1918). The Court rejected these challenges on several grounds, primarily based on the long history of the draft both in the United States and other nations. *Id.* at 379–87, 38 S. Ct. at 162–64. But it also pointed to the relationship between citizens and government: "It may not be doubted that the very [c]onception of a just government and its duty to the citizen includes the reciprocal obligation of the citizen to render military service in case of need and the right to compel it." *Id.* at 378, 38 S. Ct. at 161.

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[90] *See, e.g.*, U.S. CONST. art. I, § 2 ("[An] Enumeration shall be made within three Years after the first Meeting of the Congress of the United States, and within every subsequent Term of ten Years, in such Manner as they shall by Law direct."); *id.* art. I, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes"); *id.* art. I, § 8, cl. 12 (providing Congress with power "[t]o raise and support Armies"); *id.* art. III, § 2 ("The Trial of all Crimes, except in Cases of Impeachment, shall be by Jury.").

It is striking by comparison how very different this economic mandate is from the draft. First, it does not represent the solution to a duty owed to the government as a condition of citizenship. Moreover, unlike the draft, it has no basis in the history of our nation, much less a long and storied one. Until Congress passed the Act, the power to regulate commerce had not included the authority to issue an economic mandate. Now Congress seeks not only the power to reach a new class of "activity"—financial decisions whose effects are felt some time in the future—but it wishes to do so through a heretofore untested power: an economic mandate.

Having established the unprecedented nature of the individual mandate and the lack of any Supreme Court case addressing this issue, we are left to apply some basic Commerce Clause principles derived largely from *Wickard*, *Lopez*, *Morrison*, and *Raich*.

D. *Wickard* and Aggregation

It is not surprising that *Wickard*, which the *Lopez* Court considered "perhaps the most far reaching example of Commerce Clause authority over intrastate activity,"[91] 514 U.S. at 560, 115 S. Ct. at 1630, provides perhaps the best perspective on an economic mandate. Congress's restrictions on Roscoe Filburn's wheat acreage potentially forced him to purchase wheat on the open market. In doing so, Congress was able to artificially inflate the price of wheat by simultaneously decreasing supply and increasing demand. But *Wickard* is striking not for its similarity to our present case, but in how different it is. Although *Wickard* represents the zenith of Congress's powers under the Commerce Clause, the wheat regulation therein is remarkably less intrusive than the individual mandate.

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[91] Some have argued that *Raich* now represents the high-water mark of Congress's commerce authority. We discuss *Raich* in more detail below.

Despite the fact that Filburn was a commercial farmer[92] and thus far more amenable to Congress's commerce power than an ordinary citizen, the legislative act did not require him to purchase more wheat. Instead, Filburn had any number of other options open to him. He could have decided to make do with the amount of wheat he was allowed to grow. He could have redirected his efforts to agricultural endeavors that required less wheat. He could have even ceased part of his farming operations. The wheat-acreage regulation imposed by Congress, even though it lies at the outer bounds of the commerce power, was a limitation—not a mandate—and left Filburn with a choice. The Act's economic mandate to purchase insurance, on the contrary, leaves no choice and is more far-reaching.

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[92] In enacting the Agricultural Adjustment Act at issue in *Wickard*, Congress apparently sought to avoid reaching subsistence farmers whose production did not leave surplus for sale. Thus, it exempted small farms from the quota. *See Wickard*, 317 U.S. at 130 n.30, 63 S. Ct. at 92 n.30. In other words, Congress's regulation only applied to suppliers operating in the stream of commerce, even though some of those market suppliers also consumed a portion of wheat at home.

Although this distinction appears, at first blush, to implicate liberty concerns not at issue on appeal,[93] in truth it strikes at the heart of whether Congress has acted within its enumerated power. Individuals subjected to this economic mandate have not made a voluntary choice to enter the stream of commerce, but instead are having that choice imposed upon them by the federal government. This suggests that they are removed from the traditional subjects of Congress's commerce authority, in the same manner that the regulated actors in *Lopez* and *Morrison* were removed from the traditional subjects of Congress's commerce authority by virtue of the noneconomic cast of their activity.

This departure from commerce power norms is made all the more salient when we consider principles of aggregation, the chief addition of *Wickard* to the Commerce Clause canon. Aggregation may suffice to bring otherwise nonregulable, "trivial" instances of intrastate activity within Congress's reach if the cumulative effect of this class of activity (*i.e.*, the intrastate activity "taken together with that of many others similarly situated") substantially affects interstate commerce. *Wickard*, 317 U.S. at 127–28, 63 S. Ct. at 90. Aggregation is a doctrine that allows Congress to apply an otherwise valid regulation to a class of intrastate activity it might not be able to reach in isolation.[94]

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[93] Among other counts, the district court dismissed the plaintiffs' substantive due process challenge under the Fifth Amendment. *Florida v. HHS*, 716 F. Supp. 2d at 1161–62. That ruling is not on appeal.

In *Morrison* and *Lopez*, the Supreme Court declined to apply aggregation to the noneconomic activity at issue, reasoning that "in every case where we have sustained federal regulation under the aggregation principle in [*Wickard*], the regulated activity was of an apparent commercial character." *Morrison*, 529 U.S. at 611 n.4, 120 S. Ct. at 1750 n.4. The Court thereby resisted "additional expansion" of the substantial effects and aggregation doctrines. *Lopez*, 514 U.S. at 567, 115 S. Ct. at 1634.

The question before us is whether Congress may regulate individuals outside the stream of commerce, on the theory that those "economic and financial decisions" to avoid commerce *themselves* substantially affect interstate commerce. Applying aggregation principles to an individual's decision not to purchase a product would expand the substantial effects doctrine to one of unlimited scope. Given the economic reality of our national marketplace, any person's decision not to purchase a good would, when aggregated, substantially affect interstate commerce in that good.[95] From a doctrinal standpoint, we see no way to cabin the government's theory only to decisions not to purchase *health insurance*. If an individual's mere decision not to purchase insurance were subject to *Wickard's* aggregation principle, we are unable to conceive of *any* product whose purchase Congress could not mandate under this line of argument.[96] Although any decision not to purchase a good or service entails commercial consequences, this does not warrant the facile conclusion that Congress may therefore regulate these decisions pursuant to the Commerce Clause. *See id.* at 580, 115 S. Ct. at 1640 (Kennedy, J., concurring) ("In a sense any conduct in this interdependent world of ours has an ultimate commercial origin or consequence, but we have not yet said the commerce power may reach so far.").

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[94] Although not made explicit in *Wickard*, the courts have come to recognize aggregation as flowing from Congress's powers to enact laws necessary and proper to effectuate its power under the Commerce Clause. *See, e.g.*, *Raich*, 545 U.S. at 22, 125 S. Ct. at 2209; *id.* at 34, 125 S. Ct. at 2216 (Scalia, J., concurring); *Katzenbach*, 379 U.S. at 301–302, 85 S. Ct. at 382.

[95] Perhaps we can conceive of a purely intrastate good that is wholly insulated from the interstate market and, therefore,

Thus, even assuming that decisions *not* to buy insurance substantially affect interstate commerce, that fact alone hardly renders them a suitable

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whose purchase Congress may not mandate even under the government's sweeping extension of *Wickard's* aggregation principle. To the extent such hypothetical goods exist, their number is vanishingly small.

[96] The CBO suggested the possibility of this perilous course when it warned that an individual mandate to buy health insurance could "open the door to a mandate-issuing government taking control of virtually any resource allocation decision that would otherwise be left to the private sector . . . . In the extreme, a command economy, in which the President and the Congress dictated how much each individual and family spent on all goods and services, could be instituted without any change in total federal receipts or outlays." CBO MANDATE MEMO, *supra* p.115, at 9.

subject for regulation. *See, e.g., Morrison*, 529 U.S. at 617, 120 S. Ct. at 1754 ("We accordingly reject the argument that Congress may regulate noneconomic, violent criminal conduct *based solely on that conduct's aggregate effect on interstate commerce.*" (emphasis added)). Instead, what matters is the regulated subject matter's connection to interstate commerce. That nexus is lacking here. It is immaterial whether we perceive Congress to be regulating inactivity or a financial decision to forego insurance. Under any framing, the regulated conduct is defined by the *absence* of both commerce or even the "the production, distribution, and consumption of commodities"—the broad definition of economics in *Raich*. 545 U.S. at 25, 125 S. Ct. at 2211. To connect this conduct to interstate commerce would require a "but-for causal chain" that the Supreme Court has rejected, as it would allow Congress to regulate anything. *Morrison*, 529 U.S. at 615, 120 S. Ct. at 1752.

E. Broad Scope of Congress's Regulation

The scope of Congress's regulation also affects the constitutional inquiry. Indisputably, the health insurance and health care industries involve, and substantially affect, interstate commerce, and Congress can regulate broadly in both those realms. Nonetheless, Congress, in exercising its commerce authority, must be careful not to sweep too broadly by including within the ambit of its regulation activities that bear an insufficient nexus with interstate commerce. *See Morrison*, 529 U.S. at 613 & n.5, 120 S. Ct. at 1751–52 & n.5 (distinguishing invalidated statute from analogous statute requiring explicit interstate nexus); *Lopez*, 514 U.S. at 561–62, 115 S. Ct. at 1631 (same).

In this regard, the individual mandate's attempt to reduce the number of the uninsured and correct the cost-shifting problem is woefully overinclusive. The language of the mandate is not tied to those who do not pay for a portion of their health care (*i.e.*, the cost-shifters). It is not even tied to those who consume health care. Rather, the language of the mandate is unlimited, and covers even those who do not enter the health care market at all. Although overinclusiveness may not be fatal for constitutional purposes, the Supreme Court has indicated that it is a factor to be added to the constitutional equation.

For example, in *Lopez* the vast majority of the regulated behavior (firearm possession) did possess an interstate character.[97] However, the Supreme

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[97] A staggering proportion of the firearms in America have been transported across state lines, and thus the possessions at issue in *Lopez* likely *did* have a sufficient nexus to interstate commerce—and thus, were within Congress's regulatory authority. In the wake of *Lopez*, many defendants challenged their prosecutions under the felons-with-firearms statute—18 U.S.C. § 1202(a), later recodified as 18 U.S.C. § 922(g)—that the Supreme Court distinguished from § 922(q) by virtue of its jurisdictional element. In one such case, the government's own expert witness testified that 95% of the firearms in the United States were transported across state lines. *See* Brent E. Newton, *Felons, Firearms, and Federalism: Reconsidering* Scarborough *in Light of Lopez*, 3 J. APP. PRAC. & PROCESS 671, 681–82 & n.53 (2001).

Instructively, Congress took its cue from the Supreme Court after *Lopez* and amended the Gun-Free School Zones Act to require an explicit interstate nexus on an individualized

Court ultimately found this fact insufficient to save the statute. Rather, the Supreme Court commented that an interstate-tying element in the statute itself "would ensure, through case-by-case inquiry, that the [activity] in question affects interstate commerce."[98] *Lopez*, 514 U.S. at 561, 115 S. Ct. at 1631.

Here, the decision to forego insurance similarly lacks an established interstate tie or any "case-by-case inquiry." *See id.* Aside from the categories of exempted individuals, the individual mandate is applied across-the-board without regard to whether the regulated individuals receive, or have ever received, uncompensated care—or, indeed, seek any care at all, either now or in the future.[99] Thus, the Act contains no language "which might limit its

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basis. Specifically, Congress added a jurisdictional element to ensure that the charged individual's particular firearm had moved in interstate or foreign commerce (or otherwise affected such commerce). See 18 U.S.C. § 922(q)(2)(A) ("It shall be unlawful for any individual knowingly to possess a firearm *that has moved in or that otherwise affects interstate or foreign commerce* at a place that the individual knows, or has reasonable cause to believe, is a school zone." (emphasis added)).

[98] The *Lopez* Court never stated that such an element was *required*, and nor do we However, it is clearly a relevant constitutional factor that the Supreme Court instructs us to consider. The government's argument ignores it completely.

[99] Although health care consumption is pervasive, the plaintiffs correctly note that participation in the market for health care is far less inevitable than participation in markets for basic necessities like food or clothing.

reach to a discrete set of [activities] that additionally have an explicit connection with or effect on interstate commerce." *See id.* at 562, 115 S. Ct. at 1631.

The individual mandate sweeps too broadly in another way. Because the Supreme Court's prior Commerce Clause cases all deal with already-existing activity—not the mere *possibility* of *future* activity (in this case, health care consumption) that could implicate interstate commerce—the Court never had to address any temporal aspects of congressional regulation. However, the premise of the government's position—that most people will, *at some point in the future*, consume health care—reveals that the individual mandate is even further removed from traditional exercises of Congress's commerce power.[100]

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[100] The dissent attempts to sidestep the temporal leap problem by citing *Consolidated Edison Co. v. NLRB* for the proposition that Congress may take "reasonable preventive measures" to avoid future disruptions to interstate commerce. 305 U.S. 197, 222, 59 S. Ct. 206, 213 (1938). *Consolidated Edison*, of course, is wholly inapposite to this case, since Congress was regulating the labor practices of *utility companies* (1) fully engaged in the stream of commerce and (2) *presently* supplying economic services to instrumentalities of interstate commerce, such as railroads and steamships. *Id.* at 220–22, 59 S. Ct. at 213. Even so, the dissent's argument proves far too much. After all, by the dissent's reasoning, Congress could clearly reach the gun possession at issue in *Lopez*, since firearms are (1) objects of everyday commercial transactions and (2) are daily used to disrupt interstate commerce. *See Lopez*, 514 U.S. at 602–03, 115 S. Ct. at 1651 (Stevens, J., dissenting) ("Guns are both articles of commerce

It is true that Congress may, in some instances, regulate individuals who are consuming health care but not themselves causing the cost-shifting problem. *Cf. Raich*, 545 U.S. at 17, 125 S. Ct. at 2206 ("We have never required Congress to legislate with scientific exactitude."); *id.* at 22, 125 S. Ct. at 2209 ("That the regulation ensnares some purely intrastate activity is of no moment."). As the plaintiffs acknowledged at oral argument, when the uninsured actually enter the stream of commerce and consume health care, Congress may regulate their activity at the point of consumption.

But the individual mandate does *not* regulate behavior at the point of consumption. Indeed, the language of the individual mandate does not truly regulate "how and when health care is paid for." 42 U.S.C. § 18091(a)(2)(A). It does not even require those who consume health care to pay for it with insurance when doing so. Instead, the language of the individual mandate in fact regulates a related, but different, subject matter: "when health insurance is purchased." *Id.* If an individual's participation in the health care market is uncertain, their participation in the insurance market is even more so.

In sum, the individual mandate is breathtaking in its expansive scope. It regulates those who have

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and articles that can be used to restrain commerce. Their possession is the consequence, either directly or indirectly, of commercial activity."). Indeed, Antonio *Lopez* himself was paid $40 to traffic the gun for which he was charged under § 922(q). *United States v. Lopez*, 2 F.3d 1342, 1345 (5th Cir. 1995).

not entered the health care market at all. It regulates those who have entered the health care market, but have not entered the insurance market (and have no intention of doing so). It is overinclusive in *when* it regulates: it conflates those who presently consume health care with those who will not consume health care for many years into the future. The government's position amounts to an argument that the mere fact of an individual's existence substantially affects interstate commerce, and therefore Congress may regulate them at every point of their life. This theory affords no limiting principles in which to confine Congress's enumerated power.

F. Government's Proposed Limiting Principles

"We pause to consider the implications of the Government's arguments." *Lopez*, 514 U.S. at 564, 115 S. Ct. at 1632. The government clearly appreciates the far-reaching implications of the individual mandate. The government has struggled to avoid the conclusion that Congress may order Americans' other economic decisions through the use of economic mandates. At oral argument, the government's counsel specifically disclaimed the argument that Congress could compel a person to purchase insurance solely on the basis of his financial decision to spend his money elsewhere. Rather, the government seems to view an economic mandate as an emergency tool of sorts, for use in extreme and unique situations and only to the extent the underlying regulated conduct meets a number of fact-based criteria.

The government submits that health care and health insurance are factually unique and not susceptible of replication due to: (1) the inevitability of health care need; (2) the unpredictability of need; (3) the high costs of health care; (4) the federal requirement that hospitals treat, until stabilized, individuals with emergency medical conditions, regardless of their ability to pay;[101] (5) and associated cost-shifting.

The first problem with the government's proposed limiting factors is their lack of *constitutional* relevance.[102] These five factual criteria comprising the government's "uniqueness" argument are not limiting principles rooted in any constitutional understanding of the commerce power. Rather, they are *ad hoc* factors that—fortuitously—happen to apply to the health insurance and health care industries. They speak more to the complexity of the problem being regulated than the regulated decision's relation to interstate commerce. They are not limiting principles, but limiting circumstances.

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[101] *See* EMTALA, 42 U.S.C. § 1395dd. In this regard, the plaintiffs point out that the government's contention amounts to a bootstrapping argument. Under the government's theory, Congress can enlarge its own powers under the Commerce Clause by legislating a market externality into existence, and then claiming an extra-constitutional fix is required.

[102] The Supreme Court has rejected similar calls for a reprieve from Commerce Clause restraints based upon the ostensible uniqueness or gravity of the problem being regulated. For instance, Justice Breyer's dissent in *Lopez* attempted to deflect the majority's focus on limiting principles—specifically, its statement that upholding § 922(q) would enable the federal government to "regulate any activity that it found was related to the economic productivity of individual citizens," 514 U.S. at 564, 115 S. Ct. at 1632—by arguing that § 922(q) "is aimed at curbing a *particularly acute threat*" and that "guns and education are incompatible" in a "*special way*." *Id.* at 624, 115 S. Ct. at 1661 (Breyer, J., dissenting) (emphasis added). The dissent further opined that gun possession in schools embodied "*the rare case* . . . [when] a statute strikes at conduct that (when considered in the abstract) seems so removed from commerce, but which (practically speaking) has so significant an impact upon

Apparently recognizing that these factors appear in many subjects worthy of regulation, the government acknowledged at oral argument that the mere presence of many of these factors is not sufficient. Presented with three examples of industries characterized by some or all of these market deficiencies—elder care, other types of insurance, and the energy market—the government argued that an economic mandate in these three settings is distinguishable.

However, virtually all forms of insurance entail decisions about timing and planning for unpredictable events with high associated costs—insurance protecting against loss of life, disability from employment, business interruption, theft, flood, tornado, and other natural disasters, long-term nursing care requirements, and burial costs. Under the government's proposed limiting principles, there is no reason why Congress could not similarly

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commerce." *Id.* at 624, 115 S. Ct. at 1662 (emphasis added). The majority dismissed these "suggested limitations," however, characterizing them as "devoid of substance." *Id.* at 564, 115 S. Ct. at 1632 (majority opinion).

compel Americans to insure against any number of unforeseeable but serious risks.[103] High costs and cost-shifting in premiums are simply not limited to hospital care, but occur when individuals are disabled, cannot work, experience an accident, need nursing care, die, and myriad other insurance-related contingencies.

This gives rise to a second fatal problem with the government's proposed limits: administrability. We are at a loss as to how such fact-based criteria can serve as the sort of "judicially enforceable" limitations on the commerce power that the Supreme Court has repeatedly emphasized as necessary to that *enumerated* power. *Lopez*, 514 U.S. at 566, 115 S. Ct. at 1633; *see also Morrison*, 529 U.S. at 608 n.3, 120 S. Ct. at 1749 n.3 (rejecting dissent's "remarkable theory that the commerce power is without judicially enforceable boundaries"). We are loath to invalidate an act of Congress, and do so only after extensive circumspection. But the role that the Court would take were we to adopt the position of the government is far more troublesome.

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[103] The government essentially argues that anyone creates a cost-shifting risk by virtue of being alive, since they may one day be injured or sick and seek care that they do not pay for. Therefore, Congress can compel the purchase of health insurance, from birth to death, to protect against such risks. This expansive theory could justify the compelled purchase of innumerable forms of insurance, however. To give but one example, Congress could undoubtedly require every American to purchase liability insurance, lest the consequences of their negligence or inattention lead to unfunded costs (medical and otherwise) passed on to others in the future.

Were we to adopt the "limiting principles" proffered by the government, courts would sit in judgment over every economic mandate issued by Congress, determining whether the level of participation in the underlying market, the amount of cost-shifting, the unpredictability of need, or the strength of the moral imperative were enough to justify the mandate.

But the commerce power does not admit such limitations; rather it "is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution." *Gibbons*, 22 U.S. at 196. If Congress may compel individuals to purchase health insurance from a private company, it may similarly compel the purchase of other products from private industry, regardless of the "unique conditions" the government cites as warrant for Congress's regulation here. *See* Government's Opening Br. at 19.

Moreover, the government's insistence that we defer to Congress's fact findings underscores the lack of any judicially enforceable stopping point to the government's "uniqueness" argument. Presumably, a future Congress similarly would be able to articulate a unique problem requiring a legislative fix that entailed compelling Americans to purchase a certain product from a private company. The government apparently seeks to set the terms of the limiting principles courts should apply, and then asks that we defer to Congress's judgment about whether those conditions have been met. The Supreme Court has firmly rejected such calls for judicial abdication in the Commerce Clause realm. *See Lopez*, 514 U.S. at 557 n.2, 115 S. Ct. at 1629 n.2 ("'[W]hether particular operations affect interstate commerce sufficiently to come under the constitutional power of Congress to regulate them is ultimately a judicial rather than a legislative question, and can be settled finally only by this Court.'" (quoting *Heart of Atlanta Motel*, 379 U.S. at 273, 85 S. Ct. at 366 (Black, J., concurring))).

At root, the government's uniqueness argument relies upon a convenient sleight of hand to deflect attention from the central issue in the case: what is the nature of the conduct being regulated by the individual mandate, and may Congress reach it? Because an individual's decision to forego purchasing a product is so incongruent with the "activities" previously reached by Congress's commerce power, the government attempts to limit the individual mandate's far- reaching implications. Accordingly, the government adroitly and narrowly redefines the regulated activity as the uninsured's health care *consumption* and attendant *cost-shifting*, or the *timing and method of payment* for such consumption.[104]

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[104] The dissent adopts the government's position. *See* Dissenting Op. at 227 (describing "the relevant conduct targeted by Congress" as "the uncompensated consumption of health care services by the uninsured"); *id.* at 235 (stating that "many of the[] uninsured currently consume health care services for which they cannot or do not pay" and "[t]his is, in every real and meaningful sense, classic economic *activity*"); *id.* at 214 ("In other words, the individual mandate is the means Congress adopted to regulate the *timing* and *method* of individuals' payment for the consumption of health care services.").

The government's reluctance to define the conduct being regulated as the decision to forego insurance is understandable. After all, if the decision to forego purchasing a product is deemed "economic activity" (merely because it is inevitable that an individual in the future will consume in a related market), then decisions *not* to purchase a product would be subject to the sweeping doctrine of aggregation, and such no-purchase decisions of all Americans would fall within the federal commerce power. Consequently, the government could no longer fall back on "uniqueness" as a limiting factor, since Congress could enact purchase mandates no matter how pedestrian the relevant product market.

As an inferior court, we may not craft new dichotomies—"uniqueness" versus "non-uniqueness," or "cost-shifting" versus "non-cost-shifting"—not recognized by Supreme Court doctrine. To do so would require us to fabricate out of whole cloth a five-factor test that lacks any antecedent in the Supreme Court's Commerce Clause jurisprudence. Thus, not only do the "uniqueness" factors lack judicial administrability, present Commerce Clause doctrine prohibits inferior courts, like us, from applying them anyway.

Ultimately, the government's struggle to articulate cognizable, judicially administrable limiting principles only reiterates the conclusion we reach today: there are none.

G. Congressional Findings

This brings us to the congressional findings. *See* 42 U.S.C. § 18091(a)(1)–(3). We look to congressional findings to help us "evaluate the legislative judgment that the activity in question substantially affected interstate commerce." *Lopez*, 514 U.S. at 549, 115 S. Ct. at 1632.

Here, tracking the language of Supreme Court decisions, the congressional findings begin with the statement that the individual insurance mandate "is commercial and economic in nature" and "substantially affects interstate commerce." 42 U.S.C. § 18091(a)(1). Of course, the relevant inquiry is not whether the regulation itself substantially affects interstate commerce but rather whether the *underlying activity* being regulated substantially affects interstate commerce.

Later on, the findings do ground the individual mandate in Congress's effort to address this multi-step cost-shifting scenario: (1) some uninsureds consume health care; (2) in turn, some of them do not pay their full medical costs and instead shift them to medical providers; (3) medical providers thereafter shift these costs to "private insurers"; and (4) private insurers then shift them to insureds through higher premiums. [105] *Id.* § 18091(a)(2). The average annual premium increase is $1,000 for insured families, *id.*, and $400 for individuals.[106] The findings state that the mandate will reduce the number of the uninsured and the $43 billion cost-shifting and thereby "lower health insurance premiums."[107] *Id.* § 18091(a)(2)(F).

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[105] The parties and *amici* use the shorthand terms "cost-shifting," "cost-shifters," or "freeriders" to describe these problems.

[106] *See* Families USA, *supra* note 8.

Of course, "the existence of congressional findings is not sufficient, by itself, to sustain the constitutionality of Commerce Clause legislation." *Morrison*, 529 U.S. at 614, 120 S. Ct. at 1752. Rather, the Supreme Court has insisted that courts examine congressional findings regarding substantial effects. *See Lopez*, 514 U.S. at 557 n.2, 115 S. Ct. at 1629 n.2 ("'[S]imply because Congress may conclude that a particular activity substantially affects interstate commerce does not necessarily make it so.'" (quoting *Hodel*, 452 U.S. at 311, 101 S. Ct. at 2391 (Rehnquist, J., concurring))).

As a preliminary matter, we recount what the record reveals regarding the cost-shifting effects of the uninsured. To the extent the data show anything, the data demonstrate that the cost-shifters are largely persons who either (1) are exempted from the mandate, (2) are excepted from the mandate penalty, or (3) are now covered by the Act's Medicaid expansion.

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[107] Experts debate whether the Act will accomplish its premium-lowering objective. According to even the CBO, "Under PPACA and the Reconciliation Act, premiums for health insurance in the individual market will be somewhat higher than they would otherwise be . . . mostly because the average insurance policy in that market will cover a larger share of enrollees' costs for health care and provide a slightly wider range of benefits." CONG. BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 8 (2009).

The CBO estimates the Act will cause costs for health insurance in the individual market to rise by 27% to 30% over current levels in 2016, due to the broadened coverage achieved by the insurance market reforms. *Id.* at 6. For the purpose of our analysis, however, we accept the congressional finding that cost-shifters lead to higher premiums.

For example, illegal aliens and other nonresidents are cost-shifters ($8.1 billion, or 18.9% of the $43 billion), [108] but they are exempted from the individual mandate entirely. 26 U.S.C. § 5000A(d)(3). Low-income persons are the largest segment of cost-shifters ($15 billion, or 34.8% of the $43 billion),[109] but they are covered by the Act's Medicaid expansion or excepted from the mandate penalty. *Id.* § 5000A(e)(1), (2) (excepting individuals (1) whose premium contribution exceeds 8% of household income *or* (2) whose household income is below the specified income tax filing threshold). Previously, the uninsured with preexisting health conditions sought, but were denied, coverage and ended up in the past cost-shifting pool ($8.7 billion, or 20.1%).[110] However, the Act's insurance reforms now guarantee them coverage and move them out of the future cost-shifting pool. Already-insured persons who do not pay their out-of-pocket costs (such as copayments and deductibles) are cost-shifters ($3.3 billion, or 7.6%),[111] but they are already covered by insurance without the mandate. In addition, the cost-shifter uninsureds who cannot pay the average $2,000 medical bill also cannot pay the average $4,500 premium,[112] yielding another disconnect.

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[108] *See* Br. of *Amici Curiae* Economists in Support of Plaintiffs at 11 & app. A (summarizing their calculations based on the MEPS data set).

[109] *See* Br. of *Amici Curiae* Economists in Support of Plaintiffs at 11 & app. A (summarizing their calculations based on the MEPS data set).

[110] *See* Br. of *Amici Curiae* Economists in Support of Plaintiffs at 11 & app. A (summarizing their calculations based on the MEPS data set).

In reality, the primary persons regulated by the individual mandate are not cost-shifters but *healthy individuals* who forego purchasing insurance. The Act confirms as much. To help private insurers, the congressional findings acknowledge that the individual mandate seeks to "broaden the health insurance risk pool to include healthy individuals," to "minimize adverse selection,"[113] to increase "the size of purchasing pools," and to promote "economies of scale." 42 U.S.C. § 18091(a)(2)(I), (J). The individual mandate forces healthy and voluntarily uninsured individuals to purchase insurance from private insurers and pay premiums *now* in order to subsidize the private insurers' costs in covering more unhealthy individuals under the Act's reforms. Congress sought to mitigate its reforms' regulatory costs on private insurers[114] by compelling healthy Americans *outside the insurance market* to enter the private insurance market and buy the insurers' products. This starkly evinces how the Act is forcing market entry by those outside the market.

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[111] *See* Br. of *Amici Curiae* Economists in Support of Plaintiffs at 11 & app. A (summarizing their calculations based on the MEPS data set).

[112] 112As noted earlier, the uninsureds' average medical care costs were $2,000 in 2007 and $1,870 in 2008. Some uninsureds incur a larger expense, some a smaller expense, and some no expense at all. We use the average cited in the Brief of the *Amici Curiae* Economists in Support of the Government, at 16, which is based on the MEPS tables. The CBO estimates that in 2016 the annual premium for a bronze level plan, even in the Exchanges, will average $4,500–5,000 for individuals and $12,000–12,500 for a family policy. Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Olympia Snowe, U.S. Senator (Jan. 11, 2010), *available at* http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf.

[113] Distinguished economists have filed helpful briefs on both sides of the case. While they disagree on some things, they

Nevertheless, we need not, and do not, rely on the factual disparity between the persons regulated by the individual mandate and the cost-shifting problem. After all, courts "need not determine whether respondents' activities, taken in the aggregate, substantially affect interstate commerce *in fact*, but only whether a '*rational basis*' exists for

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agree about the theory of adverse selection. They agree some relatively healthy people refrain from, or opt out of, buying health insurance more often than people who are unhealthy or sick seek insurance. This results in a smaller and less healthy pool of insured persons for private insurance companies. Br. of *Amici Curiae* Economists in Support of the Government at 17–18; Br. of *Amici Curiae* Economists in Support of Plaintiffs at 13–16.

[114] As explained above, the Act requires private insurers (1) to cover the unhealthy and (2) *to price that coverage*, not on actuarial risks or basic economic pricing decisions, but on community-rated premiums without regard to health status. 42 U.S.C. § 300gg-1(a).

so concluding."[115] *Raich*, 545 U.S. at 22, 125 S. Ct. at 2208 (emphasis added). The government would have this be the end of the constitutional inquiry.

But the government skips important analytical steps. Rational basis review is not triggered by the mere fact of Congress's invocation of Article I power; rather, the Supreme Court has applied rational basis review to a more specific question under the Commerce Clause: whether Congress has a "rational basis" for concluding that the regulated "activities, *when taken in the aggregate*, substantially affect interstate commerce."[116] *Id.* (emphasis added). As discussed in subsection D, *supra*, courts must initially assess whether the subject matter targeted by the regulation is suitable for aggregation in the first place. Relatedly, courts, in the rational basis inquiry, must also examine whether the link between the regulated activity and interstate commerce is too attenuated, lest there be no discernible stopping point to Congress's commerce power.[117] *See Lopez*, 514 U.S. at 562–68, 115 S. Ct. at 1630–34.

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[115] Notably, the *Lopez* Court recognized the same "rational basis" level of review as *Raich*. *See Lopez*, 514 U.S. at 557, 115 S. Ct. at 1629 (stating that, since the New Deal, the Supreme Court has "undertaken to decide whether a rational basis existed for concluding that a regulated activity sufficiently affected interstate commerce"). *Raich* did not adopt a more deferential review of congressional legislation than prior cases, as the Supreme Court itself acknowledged. *See* 545 U.S. at 22, 125 S. Ct. at 2208 (collecting cases).

[116] Every case the *Raich* Court cited for rational basis review is a substantial effects case. *See* 545 U.S. at 22, 125 S. Ct. at 2208 (citing *Lopez*, 514 U.S. at 557, 115 S. Ct. 1624; *Hodel*, 452 U.S. at 276–80, 101 S. Ct. 2352; *Perez*, 402 U.S. at 155–56, 91 S. Ct. 1357; *Katzenbach*, 379 U.S. at 299–301, 85 S. Ct. 377; *Heart of Atlanta Motel*, 379 U.S. at 252–53, 85 S. Ct. 348). In such contexts, courts will accord significant deference to Congress's assessment of whether an activity's cumulative effect on interstate commerce is "substantial" or some lesser quantum. This is an altogether separate question from (1) whether a regulated activity is amenable to aggregation analysis at all and (2) the extent of the inferential leap needed to connect the regulated activity to the effects on interstate commerce.

The wholesale deference the government would have us apply here cannot be squared with the Supreme Court's decisions in *Morrison* and *Lopez*. Here, "Congress' findings are substantially weakened by the fact that they rely so heavily on a method of reasoning that [courts] have already rejected as unworkable if we are to maintain the Constitution's enumeration of powers." *Morrison*, 529 U.S. at 615, 120 S. Ct. at 1752. It is highly instructive that the *Lopez* and *Morrison* Courts rejected a similar cost-shifting theory now propounded by the government. In examining the actual relationship between gun possession and interstate commerce, the *Lopez* Court refused to accept what it referred to as the government's "cost of crime" theory. 514 U.S. at 564, 115 S. Ct. at 1632. It did so despite the government's argument that the "costs of violent crime are substantial, and, *through the mechanism of insurance, those costs are spread throughout the population*." *Id.* at 563–64, 115 S. Ct. at 1632 (emphasis added).

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[117] *Compare Raich*, 545 U.S. at 22, 125 S. Ct. at 2209 ("[W]e have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a gaping hole in the CSA."), *Heart of Atlanta Motel*, 379 U.S. at 253, 85 S. Ct. at 355 (referring to "overwhelming evidence that discrimination by hotels and motels impedes interstate travel"), and *Wickard*, 317 U.S. at 128, 63 S. Ct. at 91 ("[A] factor of such volume and variability as home-consumed wheat would have a substantial influence on price and market conditions."), *with Morrison*, 529 U.S. at 615, 120 S. Ct. at 1752 (rejecting the government's invitation "to follow the but-for causal chain from the initial occurrence of violent crime . . . to every attenuated effect upon interstate commerce"), and *Lopez*, 514 U.S. at 564, 115 S. Ct. at 1632 ("[I]f we were to accept the Government's arguments, we are hard pressed to posit any activity by an individual that Congress is without power to regulate.").

Similarly, in *Morrison* the Supreme Court considered a stockpile[118] of congressional findings attesting to the link between domestic violence and medical costs frequently borne by third parties. *See, e.g.*, 529 U.S. at 629–36, 120 S. Ct at 1760–64 (Souter, J., dissenting); *see also id.* at 632, 120 S. Ct. at 1762 ("'Over 1 million women in the United States seek medical assistance each year for injuries sustained [from] their husbands or other partners.'" (quoting S. Rep. No. 101-545, at 37 (1990))); *id.*

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[118] In *Morrison*, "[t]he congressional findings that accompanied VAWA were so voluminous that they were removed from the text of the statute and placed in a conference report to avoid cluttering the United States Code." Melissa Irr, Note, United States v. *Morrison*; *An Analysis of the Diminished Effect of Congressional Findings in Commerce Clause Jurisprudence and a Criticism of the Abandonment of the Rational Basis Test*, 62 U. PITT. L. REV. 815, 824 (2001).

("'[E]stimates suggest that we spend $5 to $10 billion a year on health care, criminal justice, and other social costs of domestic violence.'" (quoting S. Rep. No. 103-138, at 41 (1993))).

In *Morrison*, the Supreme Court also recounted Congress's express finding that gender-motivated violence substantially affected interstate commerce "'by deterring potential victims from traveling interstate, from engaging in employment in interstate business, and from transacting with business, and in places involved in interstate commerce; . . . by diminishing national productivity, *increasing medical and other costs*, and decreasing the supply of and the demand for interstate products.'" *Id.* at 615, 120 S. Ct. at 1752 (majority opinion) (emphasis added) (quoting H.R. Conf. Rep. No. 103-711, at 385 (1994)). The *Morrison* Court did not dispute the above figures about medical costs, but instead considered them largely extraneous to the threshold question of whether the subject matter of the regulation had a sufficient nexus to interstate commerce. *See id.* at 617, 120 S. Ct. at 1754.

In both *Lopez* and *Morrison*, the Supreme Court determined that the government's cost-shifting argument provided too attenuated a link to Congress's commerce power. Under such a cost-shifting theory, "it is difficult to perceive any limitation on federal power, even in areas such as criminal law enforcement or education where States historically have been sovereign." *Lopez*, 514 U.S. at 564, 115 S. Ct. at 1632.

For example, we harbor few doubts that an individual's decisions about "marriage, divorce, and child custody," if aggregated, would have substantial effects on interstate commerce. *See id.* at 564, 115 S. Ct. at 1632. Yet, the mere fact of an activity's substantial effects on interstate commerce does not thereby render that activity an appropriate subject for Congress's plenary commerce authority. Such a holding would require the Supreme Court to overturn *Lopez* and *Morrison*.

We see no reason why the inferential leaps in this case are any less attenuated than those in *Lopez* and *Morrison*. The cost-shifting accompanying the criminal acts of violence at issue in *Lopez* and *Morrison*—hospital bills borne by third parties, property damage and insurance consequences, law enforcement expenditures and incarceration costs—is at least as apparent as the multi-step cost-shifting scenario associated with the medically uninsured. Meanwhile, in all three cases, the regulated conduct giving rise to the cost-shifting is divorced from a commercial transaction or the "production, distribution, and consumption of commodities." *Raich*, 545 U.S. at 26, 125 S. Ct. at 2211.

At best, we can say that the uninsured *may*, at some point in the *unforeseeable future*, create that cost-shifting consequence. Yet this readily leads to a scenario where we must "pile inference upon inference" to sustain Congress's legislation, a practice the Supreme Court admonishes us to avo*id*. *See Lopez*, 514 U.S. at 567, 115 S. Ct. at 1634. If anything, the temporal aspects present here, but not in *Lopez* or *Morrison*, render the regulated "activity" even *further* remote.[119]

We next explain how the individual mandate impairs important federalism concerns.

H. Areas of Traditional State Concern

Before examining the states' traditional role in regulating insurance and health care, we fully recognize that Congress has the power under the Commerce Clause to regulate broadly in those arenas. In fact, Congress has legislated expansively and constitutionally in the fields of insurance and health care. *See, e.g.*, Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996); Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, 100 Stat. 82 (1986); Employee Retirement Income Security Act of 1974 ("ERISA"), Pub. L. 93-406, 88 Stat. 829 (1974); Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (establishing Medicare and Medicaid); Federal Food, Drug, and Cosmetic Act, Pub. L. No. 75-717, 52 Stat. 1040 (1938). It is clear that Congress has enacted comprehensive legislation regarding health insurance and health care. The Act is another such example. Yet, the narrow constitutional question here is whether one provision—§ 5000A—in that massive regulation goes too far.

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[119] The dissent identifies an economic effect—cost-shifting—and essentially defines that as the activity being regulated. But the dissent's conflation of activity and effect is sheer question begging. It is no wonder, then, that the dissent makes the breathtaking assertion that there is not even a single inferential step needed to link the regulated activity here to an impact on commerce. As the dissent frames the issue, there is no lack of nexus between the regulated activity and its effects on interstate commerce because they are one and the same!

To the extent the dissent describes the conduct being regulated as the uncompensated consumption of health care services, the language of the mandate refers only to insurance and contains no reference to health care services, much less how health care services are consumed or paid for. The dissent can find no inferential leap because it has assumed away the very problem in this case, effectively treating the mandate as operating at the point of consumption. Under the dissent's reframing of the issue, the VAWA's civil-remedy provision in *Morrison* could be regarded as regulating the "consumption of health care services," because such consumption inevitably and empirically flows from gender-motivated violence.

For the individual mandate to be sustained, it must be enacted pursuant to a valid exercise of Article I power. It simply will not suffice to say that, because Congress has regulated broadly in a field, it may regulate in any fashion it pleases. The Constitution supplies Congress with various tools to effectuate its legislative power, but it also denies others. In assessing Congress's exercise of power, courts recognize that the *structural* limits embedded in the Constitution are of equal dignity to the express prohibitions—and may even be a more prevalent source of limitation. *See, e.g., Comstock*, 560 U.S. at __, 130 S. Ct. at 1968 (Kennedy, J., concurring) (rejecting notion that "the Constitution's express prohibitions" are "the only, *or even the* *principal*, constraints on the exercise of congressional power" (emphasis added)).[120]

The Supreme Court's Commerce Clause jurisprudence emphasizes that, in assessing the constitutionality of Congress's exercise of its commerce authority, a relevant factor is whether a particular federal regulation trenches on an area of traditional state concern. *See Morrison*, 529 U.S. at 611, 613, 615–16, 120 S. Ct. at 1750–51, 1753; *Lopez*, 514 U.S. at 561 n.3, 564–68, 115 S. Ct. at 1631 n.3, 1632–34. The Supreme Court has expressed concern that "Congress might use the Commerce Clause to completely obliterate the Constitution's distinction between national and local authority." *Morrison*, 529 U.S. at 615, 120 S. Ct. at 1752; *see also Raich*, 545 U.S. at 35–36, 125 S. Ct. at 2216–17 (Scalia, J., concurring); *Lopez*, 514 U.S. at 557, 567–68, 115 S. Ct. at 1628–29, 1634; *id.* at 577, 115 S. Ct. at 1638–39 (Kennedy, J., concurring) (stating that if

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[120] The Supreme Court reminds us that "the federal structure serves to grant and delimit the prerogatives and responsibilities of the States and the National Government vis-à-vis one another" and "action that exceeds the National Government's enumerated powers undermines the sovereign interests of States." *Bond*, 564 U.S. at __, __, 131 S. Ct. at 2364, 2366; *see also Gregory*, 501 U.S. at 458, 111 S. Ct. at 2399 ("This federalist structure of joint sovereigns preserves to the people numerous advantages. It assures a decentralized government that will be more sensitive to the diverse needs of a heterogenous society; it increases opportunity for citizen involvement in democratic processes; it allows for more innovation and experimentation in government; and it makes government more responsive by putting the States in competition for a mobile citizenry.").

Congress were to assume control over areas of traditional state concern, "the boundaries between the spheres of federal and state authority would blur and political responsibility would become illusory. The resultant inability to hold either branch of the government answerable to the citizens is more dangerous even than devolving too much authority to the remote central power" (citation omitted)). Coupled with this consideration, the Supreme Court recognizes that the Constitution "withhold[s] from Congress a plenary police power." *Lopez*, 514 U.S. at 566, 115 S. Ct. at 1633; *see also Morrison*, 529 U.S. at 618–19, 120 S. Ct. at 1754; *cf. Comstock*, 560 U.S. at __, 130 S. Ct. at 1964; *id.* at __, 130 S. Ct. at 1967 (Kennedy, J., concurring) (stating that the police power "belongs to the States and the States alone").

In addition, whether the regulated subject matter is an area of traditional state concern impacts three of the five *Comstock* factors pertinent to a Necessary and Proper Clause analysis: (1) whether there is a long history of federal involvement in this arena, (2) whether the statute accommodates or supplants state interests, and (3) the statute's narrow scope. 560 U.S. at __, 130 S. Ct. at 1965.

With these principles in mind, we examine whether insurance and health care qualify as areas of traditional state concern. Prior to the Supreme Court's 1944 decision in *South-Eastern Underwriters*, "the States enjoyed a virtually exclusive domain over the insurance industry." *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 539, 98 S. Ct. 2923, 2928 (1978). Thus, *South-Eastern Underwriters* was "widely perceived as a threat to state power to tax and regulate the insurance industry." *United States Dep't of Treasury v. Fabe*, 508 U.S. 491, 499–500, 113 S. Ct. 2202, 2207 (1993); *see also Cantor v. Detroit Edison Co.*, 428 U.S. 579, 608 n.4, 96 S. Ct. 3110, 3126 n.4 (1976) (Blackmun, J., concurring) ("Congress' expressed concern [was that the result in *South-Eastern Underwriters*] would 'greatly impair or nullify the regulation of insurance by the States,' bringing to a halt their 'experimentation and investigation in the area.'"). "To allay those fears, Congress moved quickly to restore *the supremacy of the States in the realm of insurance regulation.*" *Fabe*, 508 U.S. at 500, 113 S. Ct. at 2207 (emphasis added).

In 1945, a year after *South-Eastern Underwriters*, Congress passed the McCarran-Ferguson Act, 59 Stat. 33, ch. 20, 15 U.S.C. §§ 1011–1015.[121] The McCarran-Ferguson Act preserved state regulatory control over insurance, which was largely considered by Congress to be a "local matter." *W. & S. Life Ins. Co. v. State Bd. of Equalization*, 451 U.S. 648, 653, 101 S. Ct. 2070, 2075 (1981) (quoting H.R. Rep. No. 143, at 2 (1945)). The passage of the McCarran-Ferguson Act signaled Congress's recognition of the states' historical role in regulating insurance within their boundaries—and its unwillingness to supplant their vital function as a source of experimentation. *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429, 66 S. Ct. 1142, 1155 (1946) ("Obviously Congress' purpose [in passing the McCarran-Ferguson Act] was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance."); *see also Ne. Bancorp, Inc. v. Bd. of Governors of Fed. Reserve Sys.*, 472 U.S. 159, 179, 105 S. Ct. 2545, 2556 (1985) (O'Connor, J., concurring) ("The business of insurance is also of uniquely local concern . . . . [and] historically ha[s] been regulated by the States in recognition of the critical part [it] play[s] in securing the financial well-being of local citizens and businesses." (citations omitted)). Our Circuit has reached a similar conclusion. *Blue Cross & Blue Shield v. Nielsen*, 116 F.3d 1406, 1413 (11th Cir. 1997) ("Adjustment of the rights and interests of insurers, health care providers, and insureds is a subject matter that falls squarely within the zone of traditional state regulatory concerns.").

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[121] The McCarran-Ferguson Act states: (1) "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business," 15 U.S.C. § 1012(a), and (2) "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance," *id.* § 1012(b).

Thus, insurance qualifies as an area of traditional state regulation. This recognition counsels caution, and supplies reviewing courts with even greater cause for doubt when faced with an unprecedented economic mandate of dubious constitutional status. *Cf. Lopez*, 514 U.S. at 583, 115 S. Ct. at 1641 (Kennedy, J., concurring) ("The statute now before us forecloses the States from experimenting and exercising their own judgment in an area to which States lay claim by right of history and expertise, and it does so by regulating an activity beyond the realm of commerce in the ordinary and usual sense of that term.").

The health care industry also falls within the sphere of traditional state regulation. A state's role in safeguarding the health of its citizens is a quintessential component of its sovereign powers. The Supreme Court has declared that the "structure and limitations of federalism . . . allow the States great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Gonzales v. Oregon*, 546 U.S. 243, 270, 126 S. Ct. 904, 923 (2006) (quotation marks and citation omitted). Numerous Supreme Court decisions have identified the regulation of health matters as a core facet of a state's police powers. *See, e.g., Hill v. Colorado*, 530 U.S. 703, 715, 120 S. Ct. 2480, 2489 (2000) ("It is a traditional exercise of the States' police powers to protect the health and safety of their citizens." (quotation marks and citation omitted)); *Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 569, 111 S. Ct. 2456, 2462 (1991) ("The traditional police power of the States is defined as the authority to provide for the public health, safety, and morals."); *Head v. N.M. Bd. of Exam'rs in Optometry*, 374 U.S. 424, 428, 83 S. Ct. 1759, 1762 (1963) ("[T]he statute here involved is a measure directly addressed to protection of the public health, and the statute thus falls within the most traditional concept of what is compendiously known as the police power."); *Barsky v. Bd. of Regents*, 347 U.S. 442, 449, 74 S. Ct. 650, 654 (1954) ("It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power."); *Jacobson v. Massachusetts*, 197 U.S. 11, 25, 25 S. Ct. 358, 360 (1905) ("According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety."); *see also Raich*, 545 U.S. at 42, 125 S. Ct. at 2221 (O'Connor, J., dissenting) ("This case exemplifies the role of States as laboratories. The States' core police powers have always included authority to define criminal law and to protect the health, safety, and welfare of their citizens.").[122]

Although the states and the federal government both play indispensable roles in regulating matters of health, modern Supreme Court precedents have confirmed the view that the health of a state's citizens is predominantly a state-based concern: "the regulation of health and safety matters is primarily, and historically, a matter of local concern." *Hillsborough Cnty. v. Automated Med.* Labs., Inc., 471 U.S. 707, 719, 105 S. Ct. 2371, 2378 (1985). The Supreme Court similarly has stated that the narrower category of "health care" is an area of traditional state concern. *See, e.g., Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 387, 122 S. Ct. 2151, 2171 (2002) (referring to "'the field of health care'" as "'a subject of traditional state regulation'" (quoting *Pegram v. Herdrich*, 530 U.S. 211, 237, 120 S. Ct. 2143, 2158 (2000))); *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661, 115 S. Ct. 1671, 1680 (1995) ("[G]eneral health care regulation . . . historically has been a matter of local concern.").

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[122] *Gibbons*, which represents one of the Supreme Court's earliest articulations of the states' reserved police powers, also provides insight into the traditionally local nature of health laws. In *Gibbons*, Chief Justice Marshall remarked that "[i]nspection laws, quarantine laws, *health laws of every description*, as well as laws for regulating the internal commerce of a State" together "form a portion of that immense mass of legislation, which embraces every thing within the territory of a State, not surrendered to the general government: all which can be most advantageously exercised by the States themselves." 22 U.S. at 203 (emphasis added).

Here, it is undisputed that the individual mandate supersedes a multitude of the states' policy choices in these key areas of traditional state concern. Congress's encroachment upon these areas of traditional state concern is yet another factor that weighs in the plaintiffs' favor, and strengthens the inference that the individual mandate exceeds constitutional boundaries. The inference is particularly compelling here, where Congress has used an economic mandate to compel Americans to purchase and continuously maintain insurance from a private company.

We recognize the argument that, if states can issue economic mandates, Congress should be able to do so as well. Yes, some states have exercised their general police power to require their citizens to buy certain products—most pertinently, for our purposes, health insurance itself.[123] But if anything, this gives us greater constitutional concern, not less. Indeed, if the federal government possesses the asserted power to compel individuals to purchase insurance from a private company forever, it may impose such a mandate on individuals in states that have elected *not* to employ their police power in this manner.[124] After all, if and when Congress actually operates within its enumerated commerce power, Congress, by virtue of the Supremacy Clause, may ultimately supplant the states. When this occurs, a state is no longer permitted to tailor its policymaking goals to the specific needs of its citizenry. This is precisely why it is critical that courts preserve constitutional boundaries and ensure that Congress only operates within the proper scope of its enumerated commerce power.

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[123] *See, e.g.*, MASS. GEN. LAWS ch. 111M § 2 (Massachusetts law requiring residents 18 years and older to "obtain and maintain creditable coverage so long as it is deemed affordable"); N.J. STAT. ANN. § 26:15-2 (New Jersey law requiring residents 18 years and younger to "obtain and maintain health care coverage that provides hospital and medical benefits").

[124] Some states have even passed legislation providing that their citizens may *not* be required to obtain or maintain health insurance. *See, e.g.*, Utah Code Ann. § 63M-1-2505.5; Va. Code Ann. § 38.2-3430.1:1; *see also* ARIZ. CONST. Art. XXVII, § 2 ("A law or rule shall not compel, directly or indirectly, any person, employer or health care provider to participate in any health care system."). The American Legislative Exchange Council, a nonprofit membership association of state legislators, filed a helpful *amicus* brief documenting the diverse array of policies implemented by states to provide their citizens with health coverage. *See* Br. of *Amicus Curiae* American Legislative Exchange Council in Support of Plaintiffs at 21–28.

In sum, the fact that Congress has enacted this insurance mandate in an area of traditional state concern is a factor that strengthens the inference of a constitutional violation. When this federalism factor is added to the numerous indicia of constitutional infirmity delineated above, we must conclude that the individual mandate cannot be sustained as a valid exercise of Congress's power to regulate activities that substantially affect interstate commerce.

We do not reach this conclusion lightly, and we recognize that "[d]ue respect for the decisions of a coordinate branch of Government demands that we invalidate a congressional enactment only upon a plain showing that Congress has exceeded its constitutional bounds." *Morrison*, 529 U.S. at 607, 120 S. Ct. at 1748. But we believe a compelling showing has been made here, and "the federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for us to admit inability to intervene when one or the other level of Government has tipped the scales too far." *Lopez*, 514 U.S. at 578, 115 S. Ct. at 1639 (Kennedy, J., concurring) (citations omitted).

I. Essential to a Larger Regulatory Scheme

We lastly consider the government's separate contention that the individual mandate is a necessary and proper exercise of Congress's commerce power because it is essential to Congress's broader regulation of the insurance and health care markets.

The government's argument derives from a Commerce Clause doctrine of recent vintage. In 1995, the *Lopez* Court commented that the Gun-Free School Zones Act was "not an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Id.* at 561, 115 S. Ct. at 1631 (majority opinion). Ten years later in *Raich*, although plainly operating within the economic-noneconomic rubric adopted in *Lopez* and *Morrison*, the Supreme Court adverted to the "essential part of a larger regulation of economic activity" language in *Lopez* as a further reason to sustain Congress's action.[125] However, several features of the individual mandate materially distinguish this case from *Raich* and demonstrate why the government's "essential to a broader regulation of commerce" argument fails here.

First, the Supreme Court has implied that the "larger regulatory scheme" doctrine primarily implicates as-applied challenges as opposed to the facial challenge at issue here. For instance, the Supreme Court has employed the "larger regulatory scheme" doctrine when a plaintiff asserts that, although Congress's statute is a permissible regulation within its commerce power, the statute cannot be validly applied to his particular intrastate activity. *Raich*, 545 U.S. at 15, 23–24, 125 S. Ct. at 2204, 2209–10. In such an instance, the Supreme Court may determine that the failure to reach a plaintiff's intrastate activities would undermine Congress's efforts to police the interstate market. *Id.* at 28, 125 S. Ct. at 2212. However, the Supreme Court has to date never sustained a statute on the basis of the "larger regulatory scheme" doctrine in a facial challenge, where plaintiffs contend that the entire class of activity is outside the reach of congressional power.[126]

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[125] In a concurring opinion, Justice Scalia stated that "Congress may regulate even *noneconomic local activity* if that regulation is a necessary part of a more general regulation of interstate commerce." *Raich*, 545 U.S. at 37, 125 S. Ct. at 2217 (Scalia, J., concurring) (emphasis added). As noted earlier, however, the majority opinion in *Raich* described the regulated activity as "the production, distribution, and consumption of commodities" and thus "quintessentially economic." *Id.* at 26, 125 S. Ct. at 2211 (majority opinion).

On this facial versus as-applied point, the *Raich* Court declared that "the statutory challenges at issue in [*Lopez* and *Morrison*] were markedly different from the challenge respondents pursue in the case at hand. Here, respondents ask us to excise individual applications of a concededly valid statutory scheme. In contrast, in both *Lopez* and *Morrison*, the parties asserted that a particular statute or provision fell outside Congress' commerce power in its entirety." *Id.* at 23, 125 S. Ct. at 2209. The Court deemed this facial versus as-applied distinction "pivotal," as "we have often reiterated that '[w]here the class of activities is regulated and that class is within the reach of federal power, the courts have no power to excise, as trivial, individual instances of the class.'" *Id.* (quoting *Perez*, 402 U.S. at 154, 91 S. Ct. at 1361). The plaintiffs here, of course, are not asking for courts to excise, as trivial, individual instances of a class—rather, the plaintiffs contend the mandate to purchase insurance from a private company falls outside of Congress's commerce power in its entirety.

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[126] Although the *Lopez* Court was the first to *recognize* the "larger regulatory scheme" doctrine, it is arguable whether they actually *applied* it, in any real sense, in that case. Rather, the Supreme Court summarily stated that § 922(q) did not implicate that doctrine at all and "cannot, therefore, be sustained under our cases upholding regulations of activities that arise out of or are connected with a commercial transaction, which viewed in the aggregate, substantially affects interstate commerce." *Lopez*, 514 U.S. at 561, 115 S. Ct. at 1631. Here, it would strain credulity to suggest that the plaintiffs' conduct "arises out of or is connected with a commercial transaction," since the very nature of their conduct is marked by the *absence* of a commercial transaction.

But even accepting that this larger regulatory scheme doctrine fully applies in facial challenges, the government's argument still fails here. To see why, we discuss how the Supreme Court utilized the doctrine in the as-applied setting of *Raich*, the only instance in which a statute has been sustained by the larger regulatory scheme doctrine. The Supreme Court in *Raich* observed that, in enacting the CSA, "Congress devised a *closed regulatory system* making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except in a manner authorized by the CSA." *Id.* at 13, 125 S. Ct. at 2203 (emphasis added). By classifying marijuana as a Schedule I drug, Congress sought to eliminate all interstate traffic in the commodity. The Supreme Court concluded that "the diversion of homegrown marijuana tends to frustrate the federal interest in eliminating commercial transactions in the interstate market *in their entirety*." *Id.* at 19, 125 S. Ct. at 2207 (emphasis added).

Additionally, the fungible nature of the commodity—*i.e.*, the inability to distinguish intrastate marijuana from interstate marijuana—also undermined Congress's ability to enforce its concededly valid total CSA ban on commercial transactions in the interstate market. The *Raich* Court stated that "[g]iven the enforcement difficulties that attend distinguishing between marijuana cultivated locally and marijuana grown elsewhere, and concerns about diversion into illicit channels, we have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a ***gaping hole*** in the CSA."[127] *Id.* at 22, 125 S. Ct. at 2209 (citation omitted) (emphasis added). Consequently, the *Raich* Court determined that Congress's regulation was justified by the possibility that the plaintiffs' intrastate activities could frustrate or impede a validly enacted congressional statute regulating interstate commerce.

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[127] The "gaping hole" identified by the Supreme Court was thrown into sharp relief by the *Raich* plaintiffs' lack of limiting principles. If Congress could not reach intrastate marijuana used for medical purposes, the *Raich* Court reasoned that it must also be true that intrastate marijuana used for *recreational* purposes could not be regulated either. 545 U.S. at 28, 125 S. Ct. at 2212. And if Congress could not reach intrastate marijuana authorized by state law, neither could itreach intrastate marijuana unauthorized by state law. *Id.* Moreover, if Congress could not reach intrastate marijuana when it is authorized by state law, then Congress's ability to police the interstate marijuana market would be wholly contingent on state decisions about whether or not to authorize marijuana use. Congress would effectively be at the mercy of states, even though "state action cannot circumscribe Congress' plenary commerce power." *Id.* at 29, 125 S. Ct. at 2213. It is easy to see how the *Raich* plaintiffs' arguments threatened to completely undermine the CSA's regulation of the interstate

In this case, the government contends that the individual mandate is essential to its broader regulation of the insurance market. For example, the government submits that Congress's insurance industry reforms—specifically, its community-rating and guaranteed-issue reforms—will encourage individuals to delay purchasing private insurance until an acute medical need arises. Therefore, the government argues that unless the individual mandate forces individuals into the private insurance pool before they get sick or injured, Congress's insurance industry reforms will be unsustainable by the private insurance companies. The government emphasizes that the congressional findings state that the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not

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marijuana market, not to mention "turn the Supremacy Clause on its head." *Id.* at 29 n.38, 125 S. Ct. at 2213 n.38.

This stands in marked contrast with the case before us, where neither state law nor the plaintiffs' uninsured status undermine the ability of Congress to enforce its regulation of interstate commerce. Even without the mandate, the integrity of all other statutory provisions is maintained, and Congress's ability to enforce the Act is in no way jeopardized.

exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(a)(2)(I).

We first note the truism that the mere placement of a particular regulation in a broader regulatory scheme does not, *ipso facto*, somehow render that regulation *essential* to that scheme. It would be nonsensical to suggest that, in announcing its "larger regulatory scheme" doctrine, the Supreme Court gave Congress *carte blanche* to enact unconstitutional regulations so long as such enactments were part of a broader, comprehensive regulatory scheme. We do not construe the Supreme Court's "larger regulatory scheme" doctrine as a magic words test, where Congress's statement that a regulation is "essential" thereby immunizes its enactment from constitutional inquiry. Such a reading would eviscerate the Constitution's enumeration of powers and vest Congress with a general police power.

Ultimately, we conclude that the Supreme Court's "larger regulatory scheme" doctrine embodies an observation put forth in the New Deal case of *Jones & Laughlin Steel Corp.*: "Although activities may be intrastate in character when separately considered, if they have such a close and substantial relation to interstate commerce that *their control is essential or appropriate to protect that commerce from burdens and obstructions*, Congress cannot be denied the power to exercise that control." 301 U.S. at 37, 57 S. Ct. at 624 (emphasis added). Justice Scalia's concurring opinion in *Raich* suggests a similar interpretation. There, he stated that the "larger regulatory scheme" statement in *Lopez* "referred to those cases permitting the regulation of intrastate activities 'which *in a substantial way* interfere with or obstruct the exercise of the granted power.'" *Raich*, 545 U.S. at 36, 125 S. Ct. at 2217 (Scalia, J., concurring) (emphasis added) (quoting *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 119, 62 S. Ct. 523, 526 (1942)). In other words, the Necessary and Proper Clause enables Congress in some instances to reach intrastate activities that markedly burden or obstruct Congress's ability to regulate interstate commerce.

In *Raich*, the plaintiffs' intrastate activities—growing and consuming marijuana—obstructed and burdened Congress's total CSA ban on interstate marijuana traffic, both because the fungible nature of marijuana frustrated Congress's ability to police the interstate market and because evidence indicated that intrastate marijuana is often diverted into the interstate market. Yet it is evident that the conduct regulated by the individual mandate—an individual's decision not to purchase health insurance and the concomitant absence of a commercial transaction—in no way "burdens" or "obstructs" Congress's ability to enforce its regulation of the insurance industry. Congress's statutory reforms of health insurance products—such as guaranteed issue and community rating—do not reference or make their implementation in any way dependent on the individual mandate.

The individual mandate does not remove an obstacle to Congress's regulation of insurance companies. An individual's uninsured status in no way interferes with Congress's ability to regulate insurance companies. The uninsured and the individual mandate also do not prevent insurance companies' regulatory compliance with the Act's insurance reforms. At best, the individual mandate is designed *not* to enable the execution of the Act's regulations, but to counteract the significant regulatory costs on insurance companies and adverse consequences stemming from the fully executed reforms. That may be a relevant political consideration, but it does not convert an unconstitutional regulation (of an individual's decision to forego purchasing an expensive product) into a constitutional means to ameliorate adverse cost consequences on private insurance companies engendered by Congress's broader regulatory reform of their health insurance products.[128]

The government's assertion that the individual mandate is "essential" to Congress's broader economic regulation is further undermined by components of the Act itself. In *Raich*, Congress devised a "closed regulatory system," *id.* at 13, 125 S. Ct. at 2203, designed to eliminate *all* interstate marijuana traffic. Here, by contrast, Congress itself carved out eight broad exemptions and exceptions to the individual mandate (and its penalty) that impair its scope and functionality. *See* 26 U.S.C. § 5000A(d)–(e). Even if the individual mandate remained intact, the "adverse selection" problem identified by Congress would persist not only with respect to these eight broad exemptions, but also with respect to *those healthy persons who choose to pay the mandate penalty. Those who pay the penalty* one year instead of purchasing insurance may still get sick the next year and then decide to purchase insurance, for which they could not be denied.

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[128] The government argues that Congress has broad authority to select the means by which it enforces its comprehensive regulatory scheme. But this hardly entails that Congress may choose any and all means whatsoever. Indeed, Congress might have employed other unconstitutional means to render its community-rating and guaranteed-issue reforms more "effective." For example, it might order unreasonable searches and seizures of corporate documents to ensure that insurance companies were not discriminating against applicants with preexisting conditions. Surely this action would not cease being a Fourth Amendment violation merely because it is deemed essential to a broader regulatory scheme.

Additionally, Congress has hamstrung its own efforts to ensure compliance with the mandate by opting for toothless enforcement mechanisms. Eschewing the IRS's traditional enforcement tools, the Act waives all criminal penalties for noncompliance and prevents the IRS from using liens or levies to collect the penalty. *Id.* § 5000A(g)(2). Thus, to the extent the uninsureds' ability to delay insurance purchases would leave a "gaping hole" in Congress's efforts to reform the insurance market, Congress has seen fit to bore the hole itself.

J. Conclusion

For these reasons, we conclude that the individual mandate contained in the Act exceeds Congress's enumerated commerce power. This conclusion is limited in scope. The power that Congress has wielded via the Commerce Clause for the life of this country remains undiminished. Congress may regulate commercial actors. It may forbid certain commercial activity. It may enact hundreds of new laws and federally-funded programs, as it has elected to do in this massive 975-page Act. But what Congress cannot do under the Commerce Clause is mandate that individuals enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die.

It cannot be denied that the individual mandate is an unprecedented exercise of congressional power. As the CBO observed, Congress "has never required people to buy any good or service as a condition of lawful residence in the United States." CBO MANDATE MEMO, *supra* p.115, at 1. Never before has Congress sought to *regulate* commerce by compelling non-market participants to *enter into* commerce so that Congress may regulate them. The statutory language of the mandate is not tied to health care consumption—past, present, or in the future. Rather, the mandate is to buy insurance now and forever. The individual mandate does not wait for market entry.

Because the Commerce Clause is an enumerated power, the Supreme Court's decisions all emphasize the need for judicially enforceable limitations on its exercise. The individual mandate embodies no such limitations, at least none recognized by extant Commerce Clause doctrine. If an individual's decision *not* to purchase an expensive product is subject to the sweeping doctrine of aggregation, then that purchase decision will almost always substantially affect interstate commerce. The government's five factual elements of "uniqueness," proposed as constitutional limiting principles, are nowhere to be found in Supreme Court precedent.

Rather, they are *ad hoc*, devoid of constitutional substance, incapable of judicial administration—and, consequently, illusory. The government's fact-based criteria would lead to expansive involvement by the courts in congressional legislation, requiring us to sit in judgment over when the situation is serious enough to justify an economic mandate.

This lack of limiting principles also implicates two overarching considerations within the Supreme Court's Commerce Clause jurisprudence: (1) preserving the federal-state balance and (2) withholding from Congress a general police power. *Morrison*, 529 U.S. at 617–19, 120 S. Ct. at 1754; *Lopez*, 514 U.S. at 566–68, 115 S. Ct. at 1633–34; *Jones & Laughlin Steel Corp.*, 301 U.S. at 30, 57 S. Ct. at 621. These concerns undergird the Constitution's dual sovereignty structure, ensuring that the federal government remains a government of enumerated powers.

As demonstrated at length throughout our opinion, Congress has broad power to deal with the problems of the uninsured, and it wielded that power pervasively in this comprehensive and sweeping Act. As to the individual mandate provision, however, Congress exceeded its enumerated commerce power. The structure of the Constitution interposes obstacles by design, in order to prevent the arrogation of power by one branch or one sovereign. *See Gregory*, 501 U.S. at 458, 111 S. Ct. at 2400 ("Just as the separation and independence of the coordinate branches of the Federal Government serve to prevent the accumulation of excessive power in any one branch, a healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front."). We cannot ignore these structural limits on the Commerce Clause because of the seriousness and intractability of the problem Congress sought to resolve in the Act.

The Supreme Court has often found itself forced to strike down congressional enactments even when the law is designed to address particularly difficult and universally acknowledged problems. For instance, in *Clinton v. City of New York*, 524 U.S. 417, 118 S. Ct. 2091 (1998), the Supreme Court addressed a problem of Congress's own creation—deficit spending. The Line Item Veto Act was "of first importance, for it seems undeniable the Act will tend to restrain persistent excessive spending." *Id.* at 449, 118 S. Ct. at 2108 (Kennedy, J., concurring). The problem the act addressed was momentous: "A nation cannot plunder its own treasury without putting its Constitution and its survival in peril." *Id.*

Nevertheless, the Supreme Court invalidated the Line Item Veto Act, recognizing that the Constitution establishes restraints on the power of Congress to act, even in regards to the mechanism by which it withholds or allocates funding. The fact that constitutional tools sometimes "prove insufficient[] cannot validate an otherwise unconstitutional device" because "[t]he Constitution's structure requires a stability which transcends the convenience of the moment." *Id.* at 453, 118 S. Ct. at 2110; *see also New York v. United States*, 505 U.S. at 178, 112 S. Ct. at 2429 (noting that "[n]o matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority" to supersede its constitutionally imposed boundaries); *INS v. Chadha*, 462 U.S. 919, 958–59, 103 S. Ct. 2764, 2788 (1983) ("In purely practical terms, it is obviously easier for action to be taken by one House without submission to the President; but it is crystal clear from the records of the Convention, contemporaneous writings and debates, that the Framers ranked other values higher than efficiency.").

In the same way, the difficulties posed by the insurance market and health care cannot justify extra-constitutional legislation. *See Printz*, 521 U.S. at 935, 117 S. Ct. at 2385 ("It matters not whether policymaking is involved, and no case-by-case weighing of the burdens or benefits is necessary; such [federal] commands are fundamentally incompatible with our constitutional system of dual sovereignty.").

The federal government's assertion of power, under the Commerce Clause, to issue an economic mandate for Americans to purchase insurance from a private company for the entire duration of their lives is unprecedented, lacks cognizable limits, and imperils our federalist structure. We recognize that "[t]hese are not precise formulations, and in the nature of things they cannot be." *Lopez*, 514 U.S. at 567, 115 S. Ct. at 1634. That an economic mandate to purchase insurance from a private company is an expedient solution to pressing public needs is not sufficient. As the Supreme Court counseled in *New York v. United States*,

> The result may appear 'formalistic' in a given case to partisans of the measure at issue, because

> such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day.

505 U.S. at 187, 112 S. Ct. at 2434. Although courts must give due consideration to the policy choices of the political branches, the judiciary owes its ultimate deference to the Constitution.[129]

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[129] We are at a loss as to why the dissent spends a considerable portion of its opinion on the Fifth and Tenth Amendments. As mentioned earlier, the district court dismissed the plaintiffs' Fifth Amendment claim. *Florida v. HHS*, 716 F. Supp. 2d at 1161–62. That ruling is not on appeal.

Furthermore, the plaintiffs' briefs on appeal raise no free-standing Tenth Amendment claim *as to the individual mandate*. Although the state plaintiffs' brief makes a single passing reference to the Tenth Amendment in the introduction, *see* States' Opening Br. at 3, the fact remains that the Tenth Amendment is not once cited or argued in the state plaintiffs' *individual mandate* discussion. *See* States' Opening Br. at 19–47. The private plaintiffs' brief also makes a single passing reference to the Tenth Amendment, but only in relation to how principles of federalism inform a Necessary and Proper Clause analysis. *See* Private Plaintiffs' Br. at 46.

Accordingly, we cannot consider a free-standing Tenth Amendment claim. *See, e.g.*, *Tanner Adver. Grp., L.L.C. v. Fayette Cnty.*, 451 F.3d 777, 785 (11th Cir. 2006) ("'The law is by now well settled in this Circuit that a legal claim or argument that has not been briefed before the court is deemed abandoned and its merits will not be addressed.'" (quoting

VI. CONSTITUTIONALITY OF INDIVIDUAL MANDATE UNDER THE TAX POWER

The government claims in the alternative that the individual mandate is a tax validly enacted pursuant to the Taxing and Spending Clause. The Clause provides in relevant part that "Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. CONST. art. 1, § 8, cl. 1. The government claims that the taxing power is comprehensive and plenary, and the fact that the individual mandate also has a concededly regulatory purpose is irrelevant, because "a tax 'does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed.'" Government's Opening Br. at 50 (quoting *United States v. Sanchez*, 340 U.S. 42, 44, 71 S. Ct. 108, 110 (1950)). The government claims that as long as a statute is "productive of some revenue," Congress may enact it under its taxing power. *Id.* (quoting *Sonzinsky v. United States*, 300 U.S. 506, 514, 57 S. Ct. 554, 556 (1937)). Furthermore, the government contends our review is limited because "the constitutional restraints on taxing are few" and "[t]he remedy for excessive taxation is in the hands

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Access Now, Inc. v. Sw. Airlines Co., 385 F.3d 1324, 1330 (11th Cir. 2004)) (brackets omitted)); *United States v. Jernigan*, 341 F.3d 1273, 1283 n.8 (11th Cir. 2003) (finding issue waived, despite "four passing references" in Appellant's brief, because "a party seeking to raise a claim or issue on appeal must plainly and prominently so indicate").

of Congress, not the courts." *United States v. Kahriger*, 345 U.S. 22, 28, 73 S. Ct. 510, 513 (1953), *overruled on other grounds by Marchetti v. United States*, 390 U.S. 39, 88 S. Ct. 697 (1968); *see also Kahriger*, 345 U.S. at 31, 73 S. Ct. at 515 ("Unless there are provisions, extraneous to any tax need, courts are without authority to limit the exercise of the taxing power."). Like every other court that has addressed this claim, we remain unpersuaded.

It is not surprising to us that all of the federal courts, which have otherwise reached sharply divergent conclusions on the constitutionality of the individual mandate, have spoken on this issue with clarion uniformity. Beginning with the district court in this case, all have found, without exception, that the individual mandate operates as a regulatory penalty, not a tax. *Florida v. HHS*, 716 F. Supp. 2d at 1143–44 ("I conclude that the individual mandate penalty is not a 'tax.' It is (as the Act itself says) a penalty."); *U.S. Citizens Ass'n v. Sebelius*, 754 F. Supp. 2d 903, 909 (N.D. Ohio 2010) (concluding that the individual mandate is a penalty, "agree[ing] with the thoughtful and careful analysis of Judge Vinson"); *Liberty Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611, 629 (W.D. Va. 2010) ("After considering the prevailing case law, I conclude that the better characterization of the exactions imposed under the Act for violations of the employer and individual coverage provisions is that of regulatory penalties, not taxes."); *Virginia v. Sebelius*, 728 F. Supp. 2d 768, 782–88 (E.D. Va. 2010) (concluding that the individual mandate "is, in form and substance, a penalty as opposed to a tax"); *Goudy-Bachman v. HHS*, 764 F. Supp. 2d 684, 695 (M.D.

Pa. 2011) ("The court finds that the individual mandate itself is not a tax . . . ."); *Mead v. Holder*, 766 F. Supp. 2d 16, 41 (D.D.C. 2011) ("[T]he Court concludes that Congress did not intend [the individual mandate] to operate as a tax, and therefore Defendants cannot rely on the General Welfare Clause as authority for its enactment.").

For good reason. The breadth of the taxing power, well noted by the government and its *amici*, fails to resolve the question we face: whether the individual mandate is a tax in the first place. The plain language of the statute and well-settled principles of statutory construction overwhelmingly establish that the individual mandate is not a tax, but rather a penalty. The legislative history of the Act further supports this conclusion. And as the Supreme Court has repeatedly recognized, there is a firm distinction between a tax and a penalty. *See, e.g., United States. v. La Franca*, 282 U.S. 568, 572, 51 S. Ct. 278, 280 (1931) ("The 174 two words are not interchangeable one for the other.").

The government would have us ignore all of this and instead hold that any provision found in the Internal Revenue Code that will produce revenue may be characterized as a tax. This we are unwilling to do.

A. Repeated Use of the Term "Penalty" in the Individual Mandate

"As in any case involving statutory construction, we begin with the plain language of the statute." *Hemispherx Biopharma, Inc. v. Johannesburg Consol. Invs.*, 553 F.3d 1351, 1362 (11th Cir. 2008) (citing *Consumer Prod. Safety Comm'n v. GTE*

Sylvania, Inc., 447 U.S. 102, 108, 100 S. Ct. 2051, 2056 (1980)). The plain language of the individual mandate is clear that the individual mandate is not a tax, but rather, as the statute itself repeatedly states, a "penalty" imposed on an individual for failing to maintain a minimum level of health insurance coverage in any month beginning in 2014. Title 26 U.S.C. § 5000A(a) requires "[a]n applicable individual" to "ensure that the individual . . . is covered under minimum essential coverage." 26 U.S.C. § 5000A(a). In order to enforce this requirement, Congress stated that "[i]f a taxpayer who is an applicable individual . . . fails to meet the requirement of subsection (a) for 1 or more months, then . . . there is hereby imposed on the taxpayer a *penalty* with respect to such failures." *Id.* § 5000A(b)(1) (emphasis added).

Nor could we construe Congress's choice of language as a careless one-time invocation of the word "penalty," because the remainder of the relevant provisions in § 5000A uses the same term over and over again, without exception and without ever describing the penalty as a "tax." *See, e.g.*, *id.* § 5000A(b)(3)(B) (individual "with respect to whom a *penalty* is imposed by this section" who files joint tax return "shall [along with individual's spouse] be jointly liable for such *penalty*" (emphasis added)); *id.* § 5000A(c)(1) (describing "[t]he amount of the *penalty* imposed by this section on any taxpayer for any taxable year" (emphasis added)); *id.* § 5000A(c)(2) (describing "the monthly *penalty* amount with respect to any taxpayer" (emphasis added)); *id.* § 5000A(g)(1) ("The *penalty* provided by this section shall be paid upon notice and demand by the Secretary ...." (emphasis added)); *id.* § 5000A(g)(2)(A) (providing that taxpayer "shall not be subject to any criminal prosecution or penalty" for failure "to timely pay any *penalty* imposed by this section" (emphasis added)); *id.* § 5000A(g)(2)(B) (providing that the Secretary shall not "file notice of lien" or "levy" on "any property of a taxpayer by reason of any failure to pay the *penalty* imposed by this section" (emphasis added)).

Thus, the text of the individual mandate unambiguously provides that it imposes a *penalty*. The penalty encourages compliance with the Act's requirement to obtain "minimum essential coverage" by imposing a monetary sanction on conduct that violates that requirement. The text is not unclear and was carefully selected to denote a specific meaning. As the Supreme Court most recently recognized in *United States v. Reorganized CF & I Fabricators of Utah, Inc.*, 518 U.S. 213, 116 S. Ct. 2106 (1996), "'[a] tax is an enforced contribution to provide for the support of government; a penalty ... is an exaction imposed by statute as punishment for an unlawful act.'" *Id.* at 224, 116 S. Ct. at 2113 (quoting *La Franca*, 282 U.S. at 572, 51 S. Ct. at 280). The Court further expounded upon *La Franca*: "We take *La Franca*'s statement of the distinction [between a tax and penalty] to be sufficient for the decision of this case; if the concept of penalty means anything, it means punishment for an unlawful act or omission. ..." *Id.*; *see also Dep't of Revenue of Mont. v. Kurth Ranch*, 511 U.S. 767, 779–80, 114 S. Ct. 1937, 1946 (1994) ("Whereas fines, penalties, and forfeitures are readily characterized as sanctions, taxes are typically different because they are usually motivated by revenue-raising, rather than punitive, purposes."). It is clear that the terms "tax" and "penalty" "are not interchangeable one for the other . . . . and if an exaction be clearly a penalty it cannot be converted into a tax by the simple expedient of calling it such." *La Franca*, 282 U.S. at 572, 51 S. Ct. at 280.

B. Designation of Numerous Other Provisions in the Act as "Taxes"

We add the truism that Congress knows full well how to enact a tax when it chooses to do so. And the Act contains several provisions that are unmistakably taxes. The point is amply made by simply looking at four different provisions: (1) an Excise Tax on Medical Device Manufacturers, 26 U.S.C. § 4191(a) ("There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a *tax* equal to 2.3 percent of the price for which so sold." (emphasis added)); (2) an Excise Tax on High Cost Employer-Sponsored Health Coverage, *id.* § 4980I(a)(1)–(2) (if an employee receives "excess benefit," as defined in the statute, from employer-sponsored health coverage, "there is hereby imposed a *tax* equal to 40 percent of the excess benefit" (emphasis added)); (3) an Additional Hospital Insurance Tax for High-Income Taxpayers, amending *id.* § 3101(b) (as part of Federal Insurance Contributions Act, providing that "there is hereby imposed on the income of every individual a *tax* equal to 1.45 percent of the wages . . . received by him with respect to employment" (emphasis added));[130] and (4) an Excise Tax on Indoor Tanning Services, *id.* § 5000B(a) ("There is hereby imposed on any indoor tanning service a *tax* equal to 10 percent of the amount paid for such service . . . whether paid by insurance or otherwise" (emphasis added)).

It is an unremarkable matter of statutory construction that we presume Congress did not indiscriminately use the term "tax" in some provisions but not in others. *See Duncan v. Walker*, 533 U.S. 167, 173, 121 S. Ct. 2120, 2125 (2001) ("It is well settled that where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." (quotation marks and alteration omitted)). We have little difficulty concluding that Congress intended § 5000A to operate as a penalty.

The very nature of congressional findings about the individual mandate further amplifies that Congress designed and intended to design a penalty for the failure to comply and not a tax. The source of the power, asserted by Congress, to create the mandate is directly pegged to the Commerce Clause. *See, e.g.*, 42 U.S.C. § 18091(a)(1) ("The individual responsibility requirement provided for in this section . . . is commercial and economic in nature, and substantially affects interstate commerce . . . ."); *id.* § 18091(a)(2)(B) ("Health insurance and health care services are a significant part of the national economy. . . . Private health insurance spending . . . pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.").

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[130] Indeed, this provision, which takes effect in 2013, is a 0.9% flat tax increase on an individual's wages, applicable to those earning annual wages over $200,000 ($250,000 in the case of a jointly-filed return, or $125,000 in the case of a married taxpayer filing a separate tax return). Act §§ 9015(a)(1), 10906(a), (c); HCERA, Pub. L. No. 111-152, § 1402(b)(1)(A), (3), 124 Stat. 1029, 1063 (2010), to be codified in 26 U.S.C. § 3101(b) (effective Jan. 1, 2013).

Indeed, the findings make clear that the goal of the individual mandate is not to raise revenue for the public fisc, but rather to, among other things, reduce the number of the uninsured and to create what Congress perceived to be effective health insurance markets that make health insurance more widely available. *Id.* § 18091(a)(2)(C)–(I); *see also id.* § 18091(a)(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.").

The argument that Congress need not employ the label of "tax" or expressly invoke the Taxing and Spending Clause in order to enact a valid tax is surely true, insofar as it goes. *See Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144, 68 S. Ct. 421, 424 (1948) ("[T]he constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise."). The problem with the claim, however, is not that Congress simply failed to use the term "tax," or declined to invoke the Taxing and Spending Clause when explaining the constitutional basis for enacting the individual mandate. Rather, Congress repeatedly told us that the individual mandate is a "penalty" and expressly invoked its Commerce Clause power as the foundation for the mandate. The two are not the same thing. Ultimately, we are hard pressed to construe the statute in a manner that would require us to ignore the plain text of the statute, the words repeatedly employed by Congress, well-settled principles of statutory construction, and well-settled law emphasizing the substantive distinction between a tax and a penalty.

C. Legislative History of the Individual Mandate

Even if the text were unclear—although it is not—and we were to resort to an examination of the legislative history, we would still find more of the same thing: Congress intended to impose a penalty for the failure to maintain health insurance.

Prior to the passage of the Act, earlier bills in both houses of Congress proposed an individual mandate accompanied by a "tax," as the district court noted. *See Florida v. HHS*, 716 F. Supp. 2d at 1134. Thus, for example, Section 401 of the "America's Affordable Choices Act of 2009," H.R. 3200, 111th Cong. (2009), which was introduced in the House of Representatives on July 14, 2009, provided that "there is hereby imposed a tax" on "any individual who does not meet the requirements of [maintaining minimum health insurance coverage] at any time during the taxable year." A later version of the House bill, the "Affordable Health Care for America Act," H.R. 3962, 111th Cong. § 501 (2009), passed the House of Representatives on November 7, 2009, and similarly referred to the individual mandate's enforcement mechanism as a "tax." On the Senate side, the "America's Healthy Future Act," a precursor to the Act, also used the term "tax." *See* S. 1796, 111th Cong. § 1301 (2009) ("If an applicable individual fails to [maintain minimum health insurance coverage] there is hereby imposed a tax. . . .").

Notably, however, the final version of the Act abandoned the term "tax" in favor of the term "penalty." This is no mere semantic distinction, as "[f]ew principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded *in favor of other language*." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442–43, 107 S. Ct. 1207, 1218 (1987) (emphasis added) (quotation marks omitted).

The government relies on different pieces of the legislative history, particularly the statements of individual legislators, speaking both for and against the Act, who at various times referred to the individual mandate as a "tax." *See* Government's Opening Br. at 54 (citing 156 Cong. Rec. H1854, H1882 (daily ed. Mar. 21, 2010) (statement of Rep. Miller); 156 Cong. Rec. H1824, H1826 (daily ed. Mar. 21, 2010) (statement of Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (daily ed. Dec. 22, 2009) (statement of Sen. Leahy); 155 Cong. Rec. S13,558, S13,581–82 (daily ed. Dec. 20, 2009) (statement of Sen. Baucus); 155 Cong. Rec. S12,768 (daily ed. Dec.

9, 2009) (statement of Sen. Grassley)). These assorted statements of individual legislators are of precious little value, because they are in conflict with the plain text of the statute and with more reliable indicators of congressional intent. *See Huff v. DeKalb Cnty., Ga.*, 516 F.3d 1273, 1280 (11th Cir. 2008) ("'The best evidence of [legislative] purpose is the statutory text adopted by both Houses of Congress and submitted to the President. Where that contains a phrase that is unambiguous—that has a clearly accepted meaning in both legislative and judicial practice—we do not permit it to be expanded or contracted by the statements of individual legislators or committees during the course of the enactment process.'" (alteration in original) (quoting *W. Va. Univ. Hosps., Inc. v. Casey*, 499 U.S. 83, 98–99, 111 S. Ct. 1138, 1147 (1991))).

The government argues nevertheless that the individual mandate is still "a tax in both administration and effect." Government's Opening Br. at 54. It claims that in "passing on the constitutionality of a tax law," we should be "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Id.* (quoting *Nelson v. Sears, Roebuck & Co.*, 312 U.S. 359, 363, 61 S. Ct. 586, 588 (1941)). That the individual mandate will produce some revenue and will be enforced by the Internal Revenue Service is enough, they say, to transmute the individual mandate's penalty provision into a tax.

We remain unpersuaded. Even on the government's own terms, the individual mandate does not in "practical operation" act as a tax. *See*

Nelson, 312 U.S. at 363, 61 S. Ct. at 588. The government specifically claims that the individual mandate has the character of a tax because it will produce revenue. This argument—which relies on undisputed projections by the CBO that the individual mandate will generate some four to five billion dollars in annual revenue by the end of this decade[131]—does little to address the distinction between a penalty and a tax. This is because "[c]riminal fines, civil penalties, civil forfeitures, and taxes all share certain features: They generate government revenues, impose fiscal burdens on individuals, and deter certain behavior." *Kurth Ranch*, 511 U.S. at 778, 114 S. Ct. at 1945. The Supreme Court has thus recognized, as indeed we must, that in our world of less than perfect compliance, penalties generate revenue just as surely as taxes.

Nor does the amount of projected revenue that will be collected under the individual mandate—a significant sum, to be sure—render the mandate a tax. The Supreme Court has never understood the *amount* of revenue generated by a statutory provision to have definitional value. In *Sonzinsky*, the Court considered a converse of the situation we face here, where a provision imposing a "$200 annual license tax" on firearms dealers was challenged as "not a true tax, but a penalty imposed for the purpose of suppressing traffic in a certain noxious type of firearms." 300 U.S. at 511–12, 57 S. Ct. at 554–55. The tax was "productive of some revenue," but not much. *Id.* at 514 & n.1, 57 S. Ct. at 556 & n.1 (observing that 27 dealers paid the tax in 1934, and 22 paid in 1935). That did not stop the Supreme Court from upholding the provision as a tax. The Supreme Court later interpreted *Sonzinsky* as standing for the proposition that "a tax does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed," and that proposition "applies even though *the revenue obtained is obviously negligible*." *Sanchez*, 340 U.S. at 44, 71 S. Ct. at 110 (emphasis added).

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[131] CBO, *Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act* 3 (rev. Apr. 30, 2010) [hereinafter CBO, *Payments*], *available at* http://www.cbo.gov/ftpdocs/113xx/doc11379/Individual_Mandate_ Penalties-04-30.pdf.

While the government views these cases as supportive of its argument, because they demonstrate the breadth of Congress's taxing power, the cases merely hold "that an Act of Congress which *on its face* purports to be an exercise of the taxing power is not any the less so because the tax is burdensome or tends to restrict or suppress the thing taxed." *Sonzinsky*, 300 U.S. at 513, 57 S. Ct. at 556 (emphasis added). Thus, once Congress has expressly and unmistakably indicated that a provision is a tax, courts will not "[i]nquir[e] into the hidden motives which may move Congress to exercise a power constitutionally conferred upon it." *Id.* at 513–14; 57 S. Ct. at 556. But that is not this case. Here we confront a statute that is not "on its face" a tax, but rather a penalty. What's more, the district court correctly noted that the government lacks any case precedent squarely on point. *Florida v. HHS*, 716 F. Supp. 2d at 1140.

Even ignoring Congress's deliberate choice of the term "penalty," the individual mandate on its face imposes a monetary sanction on an individual who "fails to meet the requirement" to maintain "minimum essential coverage." 26 U.S.C. § 5000A(b)(1). As we see it, such an exaction appears in every important respect to be "punishment for an unlawful act or omission," which defines the very "concept of penalty." *CF & I Fabricators*, 518 U.S. at 224, 116 S. Ct. at 2113; *see also Virginia v. Sebelius*, 728 F. Supp. 2d at 786 ("The only revenue generated under the [individual mandate] is incidental to a citizen's failure to obey the law by requiring the minimum level of insurance coverage. The resulting revenue is 'extraneous to any tax need.'" (quoting *Kahriger*, 345 U.S. at 31, 73 S. Ct. at 515)).

The government also suggests that the individual mandate operates as a tax because it is housed in the Internal Revenue Code and is collected through taxpayers' annual returns. It is true that the individual mandate is located under the section of the Code titled "Miscellaneous Excise Taxes." Yet the Code itself makes clear that Congress's choice of where to place a provision in the Internal Revenue Code has no interpretive value: "No inference, implication, or presumption of legislative construction shall be drawn or made by reason of the location or grouping of any particular section or provision or portion of this title. . . ." 26 U.S.C. § 7806(b); *see also Florida v. HHS*, 716 F. Supp. 2d at 1137 (citing same).

More significantly, not every provision in the Internal Revenue Code is a tax. Indeed, Congress placed in Chapter 68 of the Internal Revenue Code a panoply of civil *penalties*, running the gamut from broadly applicable (filing frivolous tax returns[132] or making unreasonable erroneous claims for a tax refund or credit[133]) to highly industry-specific (tampering with or failing to maintain security requirements for mechanical dye injection systems,[134] or selling or reselling adulterated diesel fuel that violates environmental standards[135]). In addition, the mandate's penalty is not treated like a tax because, as noted above, the IRS may not place liens, or levy or initiate criminal prosecution or impose any interest or criminal sanctions. All the IRS, practically speaking, may do is to offset the penalty against a tax refund. 26 U.S.C. § 5000A(g)(2)(A)–(B).

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[132] *See* 26 U.S.C. § 6702(a) (imposing "penalty of $5,000" on person who files "what purports to be a return of a tax imposed by this title" which either lacks "information on which the substantial correctness of the self-assessment may be judged" or "contains information that on its face indicates that the self-assessment is substantially incorrect").

[133] *See* 26 U.S.C. § 6676(a) ("If a claim for refund or credit with respect to income tax . . . is made for an excessive amount, unless it is shown that the claim for such excessive amount has a reasonable basis, the person making such claim shall be liable for a penalty in an amount equal to 20 percent of the excessive amount.").

[134] *See* 26 U.S.C. § 6715A(a)(1) ("If any person tampers with a mechanical dye injection system used to indelibly dye fuel . . . such person shall pay a penalty in addition to the tax (if any)."). The penalty is the greater of $25,000 or $10 for each gallon of fuel involved. *Id.* § 6715A(b)(1).

[135] *See* 26 U.S.C. § 6720A (imposing "penalty of $10,000" for each violation, "in addition to the tax on such [fuel]").

Although it is irrelevant for our purposes precisely where in the Internal Revenue Code Congress decided to place the individual mandate, *id.* § 7806(b), we observe that other chapters of the Internal Revenue Code include *penalty* provisions as well. *See, e.g., id.* § 5761(a) (imposing "a penalty of $1,000" on any person—primarily manufacturers, importers, and retailers—who willfully fails to comply with a variety of statutory duties and taxes under Chapter 52 of the Internal Revenue Code related to tobacco products and cigarettes). And Chapter 75 of the Internal Revenue Code sets forth criminal penalties, which permit courts to impose substantial fines. *Id.* § 7206 (providing that those who commit tax fraud in a variety of ways "shall be guilty of a felony and, upon conviction thereof, shall be fined not more than $100,000 ($500,000 in the case of a corporation), or imprisoned not more than 3 years, or both, together with the costs of prosecution"). While the entire list of penalties in the Internal Revenue Code is far too long to exhaust here, it is apparent that the placement of the individual mandate in the Internal Revenue Code is far from sufficient to convert the individual mandate into a "tax" and has limited value, if any at all, in determining whether the individual mandate is a tax or a penalty.

After careful review of the statute, we conclude that the individual mandate is a civil regulatory penalty and not a tax. As a regulatory penalty, the individual mandate must therefore find justification in a different enumerated power. *See Sunshine*

Anthracite Coal Co. v. Adkins, 310 U.S. 381, 393, 60 S. Ct. 907, 912 (1940) ("Congress may impose penalties in aid of the exercise of any of its enumerated powers."); *Virginia v. Sebelius*, 728 F. Supp. 2d at 788; *Florida v. HHS*, 716 F. Supp. 2d at 1143–44.

The individual mandate as written cannot be supported by the tax power.

VII. SEVERABILITY

We now turn to whether the individual mandate, found in 26 U.S.C. § 5000A, can be severed from the remainder of the 975-page Act.

A. Governing Principles

In analyzing this question, we start with the settled premise that severability is fundamentally rooted in a respect for separation of powers and notions of judicial restraint. *See Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 329–30, 126 S. Ct. 961, 967–68 (2006). Courts must "strive to salvage" acts of Congress by severing any constitutionally infirm provisions "while leaving the remainder intact." *Id.* at 329, 126 S. Ct. at 967–68. "[T]he presumption is in favor of severability." *Regan v. Time, Inc.*, 468 U.S. 641, 653, 104 S. Ct. 3262, 3269 (1984).

In the overwhelming majority of cases, the Supreme Court has opted to sever the constitutionally defective provision from the remainder of the statute. *See, e.g., Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. __, __, 130 S. Ct. 3138, 3161–62 (2010) (holding tenure provision severable from Sarbanes-Oxley Act); *New*

York v. United States, 505 U.S. at 186–187, 112 S. Ct. at 2434 (holding take-title provision severable from Low-Level Radioactive Waste Policy Amendments Act of 1985); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684–97, 107 S. Ct. 1476, 1479–86 (1987) (holding legislative veto provision severable from Airline Deregulation Act of 1978); *Chadha*, 462 U.S. at 931–35, 103 S. Ct. at 2774–76 (holding legislative veto provision severable from Immigration and Nationality Act); *Buckley v. Valeo*, 424 U.S. 1, 108–09, 96 S. Ct. 612, 677 (1976) (holding campaign expenditure limits severable from public financing provisions in Federal Election Campaign Act of 1971).[136]

Indeed, in the Commerce Clause context, the Supreme Court struck down an important provision of a statute and left the remainder of the statute intact. In *Morrison*, the Court invalidated only one provision—the civil remedies provision for victims of gender-based violence. *Morrison*, 529 U.S. at 605, 627, 120 S. Ct. at 1747, 1759. The Supreme Court did not invalidate the entire VAWA—or the omnibus

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[136] The paucity of case law supporting the plaintiffs' severability position is underscored by the lack of citation to any modern case where the Supreme Court found a legislative act inseverable. Indeed, the most recent such case cited by the plaintiffs was decided over 75 years ago, before modern severability law had even been established. *See* Private Plaintiffs' Br. At 59–62 (citing *R.R. Ret. Bd. v. Alton R. Co.*, 295 U.S. 330, 55 S. Ct. 758 (1935); *Williams v. Standard Oil Co.*, 278 U.S. 235, 49 S. Ct. 115 (1929); *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 15 S. Ct. 912 (1895), *superseded by* U.S. CONST. amend. XVI).

Violent Crime Control and Law Enforcement Act of 1994, of which it was part—even though the text of the two bills did not contain a severability clause.

As these cases amply demonstrate, the Supreme Court has declined to invalidate more of a statute than is absolutely necessary. Rather, "when confronting a constitutional flaw in a statute, we try to limit the solution to the problem." *Ayotte*, 546 U.S. at 328, 126 S. Ct. at 967. Because "[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people," courts should "act cautiously" and "refrain from invalidating more of the statute than is necessary." *Regan*, 468 U.S. at 652, 104 S. Ct. at 3269.

The Supreme Court's test for severability is "well-established": "Unless it is *evident* that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is *fully operative as a law*." *Alaska Airlines*, 480 U.S. at 684, 107 S. Ct. at 1480 (quotation marks omitted) (emphasis added). As the Supreme Court remarked in *Chadha*, divining legislative intent in the absence of a severability or non-severability clause can be an "elusive" enterprise. 462 U.S. at 932, 103 S. Ct. at 2774.

B. Wholesale Invalidation

Applying these principles, we conclude that the district court erred in its decision to invalidate the entire Act. Excising the individual mandate from the Act does not prevent the remaining provisions from being "fully operative as a law." As our exhaustive review of the Act's myriad provisions in Appendix A demonstrates, the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance. While such wholly unrelated provisions are too numerous to bear repeating, representative examples include provisions establishing reasonable break time for nursing mothers, 29 U.S.C. § 207(r); epidemiology-laboratory capacity grants, 42 U.S.C. § 300hh-31; an HHS study on urban Medicare-dependent hospitals, *id.* § 1395ww note; restoration of funding for abstinence education, *id.* § 710; and an excise tax on indoor tanning salons, 26 U.S.C. § 5000B.

In invalidating the entire Act, the district court placed undue emphasis on the Act's lack of a severability clause. *See Florida ex rel. Bondi v. HHS*, No. 3:10-CV-91-RV/EMT, __ F. Supp. 2d __, 2011 WL 285683, at *35–36 (N.D. Fla. Jan. 31, 2011). Supreme Court precedent confirms that the "ultimate determination of severability will rarely turn on the presence or absence of such a clause." *United States v. Jackson*, 390 U.S. 570, 585 n.27, 88 S. Ct. 1209, 1218 n.27 (1968). Rather, "Congress' silence is just that—silence—and does not raise a presumption against severability." *Alaska Airlines*, 480 U.S. at 686, 107 S. Ct. at 1481.

Nevertheless, the district court emphasized that an early version of Congress's health reform bill did contain a severability clause. Congress's failure to include such a clause in the final bill, the district court reasoned, "can be viewed as strong evidence that Congress recognized the Act could not operate *as intended* without the individual mandate." *Florida v. HHS*, 2011 WL 285683, at *36. The district court pushes this inference too far.

First, both the Senate and House legislative drafting manuals state that, in light of Supreme Court precedent in favor of severability, severability clauses are unnecessary unless they specifically state that all or some portions of a statute should *not* be severed. *See* Office of Legislative Counsel, U.S. Senate, *Legislative Drafting Manual*, § 131 (Feb. 1997) (providing that "a severability clause is unnecessary" but distinguishing a "nonseverability clause," which "provides that if a specific portion of an Act is declared invalid, the whole Act or some portion of the Act shall be invalid"); Office of Legislative Counsel, U.S. House of Representatives, *House Legislative Counsel's Manual on Drafting Style*, § 328 (Nov. 1995) (stating that "a severability clause is unnecessary unless it provides in detail which related provisions are to fall, and which are not to fall, if a specified key provision is held invalid").

Second, the clause present in one early version of the Act was a general severability clause, not a non-severability clause. *See* H.R. Rep. No 111-299, pt. 3, at 17 § 155 (2009), *reprinted in* 2010 U.S.C.C.A.N. 474, 537 ("If any provision of this Act . . . is held to be unconstitutional, the remainder of the provisions of this Act . . . shall not be affected."). Thus, according to Congress's own drafting manuals, the severability clause was unnecessary, and its removal should not be read as any indicator of legislative intent *against* severability. Rather, the removal of the severability clause, in short, has no probative impact on the severability question before us.

In light of the stand-alone nature of hundreds of the Act's provisions and their manifest lack of connection to the individual mandate, the plaintiffs have not met the heavy burden needed to rebut the presumption of severability. We therefore conclude that the district court erred in its wholesale invalidation of the Act.

C. Severability of Individual Mandate from Two Insurance Reforms

The severability inquiry is not so summarily answered, however, with respect to two of the private insurance industry reforms.[137] The two reforms are: guaranteed issue, 42 U.S.C. § 300gg-1 (effective Jan. 1, 2014); and the prohibition on preexisting condition exclusions, *id.* § 300gg-3.

Our pause over the severability of these two reforms is due to the fact that the congressional findings speak in broad, general terms except in one place that states, as noted earlier, that the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* § 18091(a)(2)(I). The findings in that paragraph add that if there were no mandate, "many individuals would wait to purchase health insurance until they needed care."[138] *Id.*

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[137] For ease of discussion, we refer to those two provisions collectively as the "two reforms."

[138] Section 18091(a)(2)(I) provides, in its entirety:

> Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act) [to be codified in 42 U.S.C. §§ 300gg-3, 300gg-4], if there were no

As discussed earlier, a significant number of the uninsured with preexisting conditions voluntarily tried to buy insurance but were denied coverage or had those conditions excluded, resulting in uncompensated health care consumption and cost-shifting. Congress also found that insurers' $90 billion in underwriting costs in identifying unhealthy entrants represented 26% to 30% of premium costs. *Id.* § 18091(a)(2)(J). The two reforms reduce the number of the uninsured and underwriting costs by guaranteeing issue and prohibiting preexisting condition exclusions. To benefit consumers, Congress has improved health insurance products and required insurers to cover consumers who need their products the most.

It is not uncommon that government regulations beneficial to consumers impose additional costs on the industry regulated. These two reforms obviously have significant negative effects on the business costs of insurers because they require insurers to accept unhealthy entrants, raising insurers' costs.

> requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

42 U.S.C. § 18091(a)(2)(I).

The individual mandate, in part, seeks to mitigate the reforms' costs on insurers by requiring the healthy to buy insurance and pay premiums to insurers to subsidize the insurers' costs in covering the unhealthy. Further, if there were no mandate, the argument goes, the healthy people can wait until they are sick to obtain insurance, knowing they could not then be turned away.[139]

In this regard, our severability concern is not over whether the two reforms can "fully operate as a law." They can. Rather, our severability concern is only whether "it is evident" that Congress "would not have enacted" the two insurance reforms *without* the individual mandate. *Alaska Airlines*, 480 U.S. at 684, 107 S. Ct. at 1480.

At the outset, we note that Congress could easily have included in the Act a non-severability clause stating that the individual mandate should not be severed from the two reforms. Under the legislative drafting manuals, the one instance in which a severability clause is important is where "it provides in detail which related provisions are to fall, and which are not to fall, if a specified key provision is held invalid." Office of Legislative Counsel, U.S. House of Representatives, *House Legislative Counsel's Manual on Drafting Style*, § 328; *accord* Office of Legislative Counsel, U.S. Senate, *Legislative Drafting Manual*, § 131. Congress did not include any such non-severability clause in the Act, however.

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[139] When a medical need arises, individuals cannot literally purchase insurance on the way to the hospital. Rather, the Act permits insurers to restrict enrollment to a specific open or special enrollment period. 42 U.S.C. § 300gg-1(b) (effective Jan. 1, 2014). Individuals therefore must wait for an enrollment period. And once an individual applies for insurance, the Act allows up to a 90-day waiting period for group coverage eligibility. *Id.* § 300gg-7 (effective Jan. 1, 2014). We can find no limit in the Act on the waiting period insurers can have in the individual market.

It is also telling that none of the insurance reforms, including even guaranteed issue and coverage of preexisting conditions, contain any cross-reference to the individual mandate or make their implementation dependent on the mandate's continued existence. *See United States v. Booker*, 543 U.S. 220, 260, 125 S. Ct. 738, 765 (2005) (stating that 18 U.S.C. § 3742(e) "contains critical cross-references to the (now-excised) § 3553(b)(1) and consequently must be severed and excised for similar reasons"); *Alaska Airlines*, 480 U.S. at 688–89, 107 S. Ct. at 1482 ("Congress did not link specifically the operation of the first-hire provisions to the issuance of regulations."). Indeed, § 300gg-3's prohibition on preexisting condition exclusions was implemented in 2010 with respect to enrollees under 19, despite the individual mandate not taking effect until 2014. This is a far cry from cases where the Supreme Court has ruled provisions inseverable because it would require courts to engage in quasi-legislative functions in order to preserve the provisions. *See, e.g., Randall v. Sorrell*, 548 U.S. 230, 262, 126 S. Ct. 2479, 2500 (2006) (declining to sever Vermont's campaign finance contribution limits because doing so "would require [the Court] to write words into the statute"); *see also Free Enter. Fund*, 561 U.S. at __, 130 S. Ct. at 3162 (cautioning courts against "blue-pencil[ing]").

"[T]he remedial question we must ask" is "which alternative adheres more closely to Congress' original objective" in passing the Act: (1) the Act without the individual mandate but otherwise intact; or (2) the Act without the individual mandate and also without these two insurance reforms. *See Booker*, 543 U.S. at 263, 125 S. Ct. at 766–67.

As discussed earlier, a basic objective of the Act is to make health insurance coverage accessible and thereby to reduce the number of uninsured persons. *See, e.g.*, 42 U.S.C. § 18091(a)(2) (stating the Act will "increase the number and share of Americans who are insured" and "significantly reduc[e] the number of the uninsured"). Undoubtedly, the two reforms seek to achieve those objectives. All other things being equal, then, a version of the Act that contains these two reforms would hew more closely to Congress's likely intent than one that lacks them.

But without the individual mandate, not all things are equal. We must therefore look to the consequences of the individual mandate's absence on the two reforms. *See Booker*, 543 U.S. at 260, 125 S. Ct. at 765 (considering whether excision of one part of statute would "pose a critical problem"); *Regan*, 468 U.S. at 653, 104 S. Ct. at 3269 (asking whether "the policies Congress sought to advance by enacting § 504 can be effectuated even though the purpose requirement is unenforceable"). In doing so, several factors loom large.

First, the Act retains many other provisions that help to accomplish some of the same objectives as the individual mandate. *See Booker*, 543 U.S. at 264, 125 S. Ct. at 767 ("The system remaining after excision, while lacking the mandatory features that Congress enacted, retains other features that help to further these objectives."); *New York v. United States*, 505 U.S. at 186, 112 S. Ct. at 2434 ("Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated.").

For example, Congress included other provisions in the Act, apart from and independent of the individual mandate, that also serve to reduce the number of the uninsured by encouraging or facilitating persons (including the healthy) to purchase insurance coverage. These include: (1) the extensive health insurance reforms; (2) the new Exchanges; (3) federal premium tax credits, 26 U.S.C. § 36B; (4) federal cost-sharing subsidies, 42 U.S.C. § 18071; (5) the requirement that Exchanges establish an Internet website to provide consumers with information on insurers' plans, *id.* § 18031(d)(4)(D); (6) the requirement that employers offer insurance or pay a penalty, 26 U.S.C. § 4980H; and (7) the requirement that certain large employers automatically enroll new and current employees in an employer-sponsored plan unless the employee opts out, 29 U.S.C. § 218A, just to name a few.

Second, the individual mandate has a comparatively limited field of operation vis-à-vis the number of the uninsured. In *Alaska Airlines*, the

Supreme Court found that the unconstitutional legislative veto provision of the Airline Deregulation Act (permitting Congress to veto the Labor Secretary's implementing regulations) was severable because, among other things, the statute left "little of substance to be subject to a veto." 480 U.S. at 687, 107 S. Ct. at 1481. The Supreme Court noted the "ancillary nature" of the Labor Secretary's obligations and the "limited substantive discretion" afforded the Secretary.[140] *Id.* at 688, 107 S. Ct. at 1482. Thus, the limited field of operation of an unconstitutional statutory provision furnishes evidence that Congress likely would have enacted the statute without it. *Cf. Booker*, 543 U.S. at 249, 125 S. Ct. at 759 (considering whether "the scheme that Congress created" would be "so transform[ed] . . . that Congress likely would not have intended the Act as so modified to stand").

Here, as explained above, the operation of the individual mandate is limited by its three exemptions, its five exceptions to the penalty, and its stripping the IRS of tax liens, interests, or penalties and leaving virtually no enforcement mechanism. Even with the mandate, a healthy individual can pay a penalty and wait until becoming sick to purchase insurance.

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[140] The Supreme Court stated:

> With this subsidiary role allotted to the Secretary, the veto provision could affect only the relatively insignificant actions he might take in connection with the duty-to-hire program. There is thus little reason to believe that Congress contemplated the possibility of vetoing any of these actions and one can infer that Congress would have been satisfied with the duty-to-hire provisions even without preserving the opportunity to veto the DOL's regulations.

Alaska Airlines, 480 U.S. at 688, 107 S. Ct. at 1482 (footnote omitted).

Further, the individual mandate's operation and effectiveness are limited by the fact that, although the individual mandate requires individuals to obtain insurance coverage, the mandate itself does not require them to obtain the "essential health benefits package" or, indeed, any particular level of benefits at all. Although the chosen term "minimum essential coverage" appears to suggest otherwise, when the lofty veneer of the term is stripped away, one finds that the actual "coverage" the individual mandate deems "essential" is nothing more than coverage "essential" to satisfying the individual mandate.

The multiple features of the individual mandate all serve to weaken the mandate's practical influence on the two insurance product reforms.[141] They also weaken our ability to say that Congress considered the individual mandate's existence to be a *sine qua non* for passage of these two reforms. There is tension, at least, in the proposition that a mandate engineered to be so porous and toothless is such a linchpin of the Act's insurance product reforms that they were clearly not intended to exist in its absence.

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[141] Studies by the CBO bear this out. Even with the individual mandate, the CBO estimates that in 2016, there will still be more than 21 million non-elderly persons who remain uninsured, the majority of whom will not be subject to the penalty. *See* CBO, *Payments, supra* note 131, at 1.

We are not unmindful of Congress's findings about the individual mandate. But in the end, they do not tip the scale away from the presumption of severability. As observed above, the findings in § 18091(a)(2) track the language of the Supreme Court's Commerce Clause decisions. But the severability inquiry is separate, and very different, from the constitutional analysis. The congressional language respecting Congress's constitutional authority does not govern, and is not particularly relevant to, the different question of severability (which focuses on whether Congress would have enacted the Act's *other insurance market reforms* without the individual mandate).

An example makes the point. Section 18091(a)(2)(H) of the same congressional findings provides:

> Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

42 U.S.C. § 18091(a)(2)(H). By its text, § 18091(a)(2)(H) states that the individual mandate is essential to "this larger regulation of economic activity"—that is, "regulating health insurance,"

which it does through ERISA and the Public Health Service Act. If applied to severability, this would mean that Congress intended the individual mandate to be "essential" to, and thus inseverable from, ERISA (enacted in 1974) and the entire Public Health Service Act (or at least all parts of those statutes that regulate health insurance). This is an absurd result for which no party argues.[142]

These congressional findings do not address the one question that is relevant to our severability analysis: whether Congress would not have enacted the two reforms *but for* the individual mandate. Just because the invalidation of the individual mandate may render these provisions *less desirable*, it does not ineluctably follow that Congress would find the two reforms so undesirable without the mandate as to prefer not enacting them at all. The fact that one provision may have an impact on another provision is not enough to warrant the inference that the provisions are inseverable. This is particularly true here because the reforms of health insurance help consumers who need it the most.

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[142] A second illustration of the danger in relying too much on these statements in isolation is that the same congressional findings also state—not once, but six times—that the individual mandate operates "*together with the other provisions of this Act*" to reduce the number of the uninsured, lower health insurance premiums, improve financial security for families, minimize adverse selection, and reduce administrative costs. *See* 42 U.S.C. § 18091(a)(2)(C), (E), (F), (G), (I), (J) (emphasis added). Congress itself states that *all* the provisions of the Act operate together to achieve its goals. On this reasoning, the entire Act would be invalidated along with the individual mandate. As discussed above, this conclusion is invalid.

In light of all these factors, we are not persuaded that it is *evident* (as opposed to possible or reasonable) that Congress would not have enacted the two reforms in the absence of the individual mandate.[143] In so concluding, we are mindful of our duty to "refrain from invalidating more of the statute than is necessary."[144] ***Regan***, 468 U.S. at 652, 104 S. Ct. at 3269; ***see also Booker***, 543 U.S. at 258–59, 125 S. Ct. at 764 ("[W]e must retain those portions of the Act that are (1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." (quotation marks and citations omitted)). And where it is not evident Congress would not have enacted a constitutional provision without one that is unconstitutional, we must allow any further—and perhaps even necessary—alterations of the Act to be rendered by Congress as part of that branch's legislative and political prerogative. *See Free Enter. Fund*, 561 U.S. at __, 130 S. Ct. at 3162 ("[S]uch editorial freedom—far more extensive than our holding today—belongs to the Legislature, not the Judiciary. Congress of course remains free to pursue any of these options going forward."). We therefore sever the individual mandate from the remaining sections of the Act.

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[143] While we discuss the two reforms specifically, our conclusion—that the individual mandate is severable—is the same as to the other insurance product reforms, such as community rating and discrimination based on health status.

[144] We acknowledge that the government, in arguing for the individual mandate's constitutionality, stated summarily that the individual mandate cannot be severed from the Act's guaranteed issue and community rating provisions because the individual mandate "is integral to those sections that . . . provide that insurers must extend coverage and set premiums without regard to pre-existing medical conditions." Government's Reply Br. at 58. But as explained above, whether a statutory provision is "integral" or "essential" to other provisions for Commerce Clause analytical purposes is a question distinct from severability. And in any event, the touchstone of severability analysis is legislative intent, not arguments made during litigation.

VIII. CONCLUSION

We first conclude that the Act's Medicaid expansion is constitutional. Existing Supreme Court precedent does not establish that Congress's inducements are unconstitutionally coercive, especially when the federal government will bear nearly all the costs of the program's amplified enrollments.

Next, the individual mandate was enacted as a regulatory penalty, not a revenue-raising tax, and cannot be sustained as an exercise of Congress's power under the Taxing and Spending Clause. The mandate is denominated as a penalty in the Act itself, and the legislative history and relevant case law confirm this reading of its function.

Further, the individual mandate exceeds Congress's enumerated commerce power and is unconstitutional. This economic mandate represents a wholly novel and potentially unbounded assertion of congressional authority: the ability to compel Americans to purchase an expensive health insurance product they have elected not to buy, and to make them re-purchase that insurance product every month for their entire lives. We have not found any generally applicable, judicially enforceable limiting principle that would permit us to uphold the mandate without obliterating the boundaries inherent in the system of enumerated congressional powers. "Uniqueness" is not a constitutional principle in any antecedent Supreme Court decision. The individual mandate also finds no refuge in the aggregation doctrine, for decisions to *abstain* from the purchase of a product or service, whatever their cumulative effect, lack a sufficient nexus to commerce.[145]

The individual mandate, however, can be severed from the remainder of the Act's myriad reforms. The presumption of severability is rooted in notions of judicial restraint and respect for the separation of powers in our constitutional system. The Act's other provisions remain legally operative after the mandate's excision, and the high burden needed under Supreme Court precedent to rebut the presumption of severability has not been met.

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[145] Our respected dissenting colleague says that the majority: (1) "has ignored the broad power of Congress"; (2) "has ignored the Supreme Court's expansive reading of the Commerce Clause"; (3) "presume[s] to sit as a superlegislature"; (4) "misapprehends the role of a reviewing court"; and (5) ignores that "as nonelected judicial officers, we are not afforded the opportunity to rewrite statutes we don't like." *See* Dissenting Op. at 208–209, 243. We do not respond to these contentions, especially given (1) our extensive and exceedingly careful review of the Act, Supreme Court precedent, and the parties' arguments, and (2) our holding that the Act, despite significant challenges to this massive and sweeping federal regulation and spending, falls within the ambit and prerogative of Congress's broad commerce power, except for one section, § 5000A. We do, however, refuse to abdicate our constitutional duty when Congress has acted beyond its enumerated Commerce Clause power in mandating that Americans, from cradle to grave, purchase an insurance product from a private company.

Accordingly, we affirm in part and reverse in part the judgment of the district court.

AFFIRMED in part and REVERSED in part.

MARCUS, Circuit Judge, concurring in part and dissenting in part[1]:

Today this Court strikes down as unconstitutional a central piece of a comprehensive economic regulatory scheme enacted by Congress. The majority concludes that Congress does not have the commerce power to require uninsured Americans to obtain health insurance or otherwise pay a financial penalty. The majority does so even though the individual mandate was designed and intended to regulate quintessentially economic conduct in order to ameliorate two large, national problems: first, the substantial cost shifting that occurs when uninsured individuals consume health care services—as virtually all of them will, and many do each year—for which they cannot pay; and, second, the unavailability of health insurance for those who need it most—those with pre-existing conditions and lengthy medical histories.

In the process of striking down the mandate, the majority has ignored many years of Commerce Clause doctrine developed by the Supreme Court. It has ignored the broad power of Congress, in the words of Chief Justice Marshall, "to prescribe the rule by which commerce is to be governed." *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 196 (1824). It has ignored the undeniable fact that Congress' commerce power has grown exponentially over the past two centuries, and is now generally accepted as having afforded Congress the authority to create rules regulating large areas of our national economy. It has ignored the Supreme Court's expansive reading of the Commerce Clause that has provided the very foundation on which Congress already extensively regulates both health insurance and health care services. And it has ignored the long-accepted instruction that we review the constitutionality of an exercise of commerce power not through the lens of formal, categorical distinctions, but rather through a pragmatic one, recognizing, as Justice Holmes put it over one hundred years ago, that "commerce among the states is not a technical legal conception, but a practical one, drawn from the course of business." *Swift & Co. v. United States*, 196 U.S. 375, 398 (1905).

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[1] I concur only in Parts I (standing), III (Medicaid expansion), and VI (taxing power) of the majority opinion.

The approach taken by the majority has also disregarded the powerful admonitions that acts of Congress are to be examined with a heavy presumption of constitutionality, that the task at hand must be approached with caution, restraint, and great humility, and that we may not lightly conclude that an act of Congress exceeds its enumerated powers. The circumspection this task requires is underscored by recognizing, in the words of Justice Kennedy, the long and difficult "history of the judicial struggle to interpret the Commerce Clause during the transition from the economic system the Founders knew to the single, national market still emergent in our own era." *United States v. Lopez*, 514 U.S. 549, 568 (1995) (Kennedy, J., concurring).

The plaintiffs and, indeed, the majority have conceded, as they must, that Congress has the commerce power to impose precisely the *same* mandate compelling the *same* class of uninsured individuals to obtain the *same* kind of insurance, or otherwise pay a penalty, as a necessary condition to receiving health care services, at the time the uninsured seek these services. Nevertheless, the plaintiffs argue that Congress cannot do now what it plainly can do later. In other words, Congress must wait until each component transaction underlying the cost-shifting problem occurs, causing huge increases in costs both for those who have health care insurance and for health care providers, before it may constitutionally act. I can find nothing in logic or law that so circumscribes Congress' commerce power and yields so anomalous a result.

Although it is surely true that there is no Supreme Court decision squarely on point dictating the result that the individual mandate is within the commerce power of Congress, the rationale embodied in the Court's Commerce Clause decisions over more than 75 years makes clear that this legislation falls within Congress' interstate commerce power. These decisions instruct us to ask whether the target of the regulation is economic in nature and whether Congress had a rational basis to conclude that the regulated conduct has a substantial effect on interstate commerce. It cannot be denied that Congress has promulgated a rule by which to comprehensively regulate the timing and means of payment for the virtually inevitable consumption of health care services. Nor can it be denied that the consumption of health care services by the uninsured has a very substantial impact on interstate commerce—the shifting of substantial costs from those who do not pay to those who do and to the providers who offer care. I therefore respectfully dissent from the majority's opinion insofar as it strikes down the individual mandate.

I.

A.

A considerable portion of the American population—estimated at 50 million—lacks any form of health care insurance.[2] The individual mandate was designed to ameliorate twin problems related to the uninsured as a class: (1) huge cost shifting from the uninsured, who often don't pay for their health care services, to those with health insurance and to health care providers; and (2) the inability of many uninsured individuals to obtain much-needed health insurance coverage because they are effectively blacklisted on account of their pre-existing conditions or medical histories. Congress sought to address these problems by requiring non-exempted individuals to pay a penalty, or "shared responsibility payment," on their tax returns for any month, beginning in 2014, in which they fail to maintain "minimum essential coverage." 26 U.S.C. § 5000A(a)-(b). And while remaining uninsured is not an option under the Act (at least to avoid paying a penalty), individuals are offered a variety of choices when it comes to satisfying the individual mandate's "minimum essential coverage" requirement. Many insurance plans will satisfy the individual mandate. These plans fall into five general categories, some of which are further divided into subcategories: (1) government-sponsored programs; (2) eligible employer-sponsored plans; (3) plans purchased on the individual market; (4) grandfathered health plans; or (5) any "other coverage" recognized by the Secretary of Health and Human Services ("HHS") in coordination with the Secretary of the Treasury. *Id.* § 5000A(f)(1).

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[2] In 2009, the total number of uninsured was estimated at 50.7 million, or about 16.7% of the total population. U.S. Census Bureau, U.S. Dep't of Commerce, Income, Poverty, and Health Insurance Coverage in the United States: 2009, at 23 tbl.8 (2010), *available at* http://www.census.gov/prod/2010pubs/p60-238.pdf. What's more, the population of uninsured is not confined to those with low incomes. The Census Bureau found that the estimated income brackets for the uninsured are as follows:

(1) less than $25,000: 15.5 million uninsured, about 26.6% of the total population in this income bracket;

(2) $25,000 to $49,999: 15.3 million, about 21.4%;

(3) $50,000 to $74,999: 9.4 million, about 16.0%;

(4) $75,000 or more: 10.6 million, about 9.1%.

Id.

As for the first problem Congress sought to address, it is undeniable that, despite lacking health insurance, the uninsured are still substantial participants in the market for health care services. And when the uninsured do seek medical care, they often fail to pay all or even most of their costs. On average—and these figures are not disputed—the uninsured pay only 37% of their health care costs out of pocket, while third parties pay another 26% on their behalf.[3] The remaining costs are uncompensated—they are borne by health care providers and are passed on in the form of increased premiums to individuals who already participate in the insurance market.

Congress' findings reflect its determination that this problem—the uncompensated consumption of health care services by the uninsured—has *national* economic consequences that require a *national* solution through comprehensive federal regulation. *See* 42 U.S.C. § 18091. As part of the empirical foundation for the individual mandate, Congress quantified the costs associated with the free-riding and cost-shifting problems that result from the provision of uncompensated health care to the uninsured:

> The cost of providing uncompensated care to the uninsured was ***$43,000,000,000 [$43 billion] in 2008***. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting

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[3] These figures come from a study cited by both the plaintiffs and the government: Families USA, Hidden Health Tax: Americans Pay a Premium 2 (2009) [hereinafter Hidden Health Tax], *available at* http://familiesusa2.org/assets/pdfs/hidden-healthtax.pdf. And again, the problem of uncompensated care is not confined to those of limited means. Even in households at or above the median income, people without health insurance pay, on average, less than half the cost of the medical care they consume. See Bradley Herring, *The Effect of the Availability of Charity Care to the Uninsured on the Demand for Private Health Insurance*, 24 J. Health Econ. 225, 229-31 (2005).

> increases family premiums by on average *over $1,000 a year*. By significantly reducing the number of the uninsured, the [individual mandate], together with the other provisions of this Act, will lower health insurance premiums.

Id. § 18091(a)(2)(F) (emphases added).

The Act thus seeks to regulate the payment for health care consumption through the mechanism of health insurance. As Congress found, the individual mandate "regulates activity that is commercial and economic in nature: economic and financial decisions about *how and when health care is paid for*, and when health insurance is purchased." *Id.* § 18091(a)(2)(A) (emphasis added). In other words, the individual mandate is the means Congress adopted to regulate the *timing* and *method* of individuals' payment for the consumption of health care services.

As for the second problem of millions of uninsured individuals' being unable to obtain health insurance, Congress sought to dramatically reform the health insurance market by regulating the insurers themselves. The Act bars insurers from using many of the tools they had previously employed to protect themselves against the large costs imposed by high-risk individuals. Thus, insurers may no longer deny coverage or charge higher premiums because of an individual's pre-existing conditions or medical history. *Id.* §§ 300gg(a)(1), 300gg-3(a), 300gg-4(a); Act § 2702(a) (to be codified at 42 U.S.C. § 300gg-1(a)). Under the "community rating" provision, insurers may only vary premiums based on (i) whether the plan covers an individual or a family, (ii) rating area, (iii) age, and (iv) tobacco use. 42 U.S.C. § 300gg(a)(1). And under the "guaranteed issue" provisions, insurers must accept every employer or individual who applies for coverage through the individual or group markets. Act § 2702(a) (to be codified at 42 U.S.C. § 300gg-1(a)). Notably, insurers may no longer offer plans that limit or exclude benefits for individuals' pre-existing conditions, 42 U.S.C. § 300gg-3(a), nor may they refuse to cover individuals on the basis of (i) health status, (ii) medical condition (including both physical and mental illnesses), (iii) claims experience, (iv) receipt of health care, (v) medical history, (vi) genetic information, (vii) evidence of insurability (including conditions arising out of acts of domestic violence), (viii) disability, or (ix) any other health status factor recognized by the Secretary of HHS, *id.* § 300gg-4(a).

Congress determined that the individual mandate was *essential* to the effective implementation of the Act's insurer regulations—that is, "to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* § 18091(a)(2)(I). Congress further found that waiting until the uninsured actually consume health care services before regulating them would effectively be a day late and a dollar short. *See id.* ("[I]f there were no [individual mandate], many individuals would wait to purchase health insurance until they needed care."); *Liberty Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611, 634-35 (W.D. Va. 2010) ("As Congress stated in its findings, the individual coverage provision is 'essential' to th[e] larger regulatory scheme because without it, individuals would postpone [acquiring] health insurance until they need substantial care, at which point the Act would obligate insurers to cover them at the same cost as everyone else. This would increase the cost of health insurance and decrease the number of insured individuals—precisely the harms that Congress sought to address . . . ."); Gov't Br. at 19 (citing testimony before Congress that a "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital" (internal quotation marks omitted)).

Congress also made findings supporting the proposition that the markets for health insurance and health care services are deeply and inextricably bound together and indicated clearly that it sought to regulate across them both. Congress understood that health insurance and health care consumption are linked as a factual matter. Health insurance is the means by which most of our national health care costs are paid for; in 2009, private and government insurance financed approximately 75% of health care spending. Gov't Br. at 9 (citing non-disputed data from the Centers for Medicare and Medicaid Services ("CMS")). Moreover, Congress expressly connected the increased participation in the health insurance market that it expected to result from the individual mandate with "increasing the supply of, and demand for, health care services." 42 U.S.C. § 18091(a)(2)(C). On a more basic level, Congress also understood that "[h]ealth insurance is not bought for its own sake; it is bought to pay for medical expenses." Gov't Br. at

39 (citing M. Moshe Porat et al., *Market Insurance Versus Self Insurance: The Tax-Differential Treatment and Its Social Cost*, 58 J. Risk & Ins. 657, 668 (1991); Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. Pol. Econ. 251, 253 (1973) [hereinafter Welfare Loss] ("Health insurance is purchased not as a final consumption good but as a means of paying for the future stochastic purchases of health services.")); *see also* Brief for Econ. Scholars as Amici Curiae Supporting the Government ("Gov't Econ. Br.") at 12 ("Medical care is the set of services that make one healthier, or prevent deterioration in health. Health insurance is a mechanism for spreading the costs of that medical care across people or over time, from a period when the cost would be overwhelming to periods when costs are more manageable.").

B.

1.

Congress' commerce power to regulate is, as Chief Justice Marshall taught us almost two hundred years ago, the power "to prescribe the rule by which commerce is to be governed. This power, like all others vested in Congress, is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution." *Gibbons*, 22 U.S. at 196. It is precisely this power to prescribe rules governing commerce that Congress lawfully exercised in enacting the individual mandate.

It is clear that Congress' rule-making power extends to both the health insurance and health care markets, areas of commerce that Congress has long regulated and regulated heavily. First, the parties all agree (as they must) that Congress' commerce power lawfully extends to the regulation of insurance in general, as the Supreme Court concluded more than 60 years ago in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 552-53 (1944). Indeed, Congress expressly relied on this proposition in enacting the individual mandate. *See* 42 U.S.C. § 18091(a)(3) (citing *South-Eastern Underwriters* as a basis for Congress' authority to regulate insurance under the Commerce Clause).[4]

Second, in light of Congress' undeniable power under the Commerce Clause to regulate the business of insurance generally, it follows—and again there is no dispute—that Congress may also regulate health insurance in particular, which is, after all, a subset of the insurance market. *See* Charles Fried, Written Testimony Before the Senate Judiciary Committee Hearing on "The Constitutionality of the Affordable Care Act" 1 (Feb. 2, 2011), *available at* http://judiciary.senate.gov/pdf/11-02-02%20Fried%20 Testimony.pdf. In fact, Congress has extensively exercised its commerce power to regulate the health insurance market for many years, long before the Act was passed. For example, Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA"), Pub. L. No. 93-406, 88 Stat. 829 (1974), which is a massive piece of legislation regulating the operation of employee benefit plans, including retirement plans, pension plans, and employer-provided *health insurance* plans. Congress expressly pegged the broad scope of ERISA's coverage to its Commerce Clause power. 29 U.S.C. § 1001(b) ("It is hereby declared to be the policy of this chapter to protect interstate commerce . . . ."); *see also id.* § 1003(a). Among other things, the regulatory provisions in Title I of ERISA, 29 U.S.C. § 1001 *et seq.*, set forth "uniform minimum standards to ensure that employee benefit plans are established and maintained in a fair and financially sound manner." U.S. Dep't of Labor, Health Benefits, Retirement Standards, and Workers' Compensation: Employee Benefit Plans, http://www.dol.gov/ compliance/guide/erisa.htm (last visited Aug. 10, 2011). Title I of ERISA governs "most private sector employee benefit plans," with the most significant exceptions being "plans established or maintained by government entities or churches." *Id.*; *see also Williams v. Wright*, 927 F.2d 1540, 1545 (11th Cir. 1991) (concluding that ERISA regulates even "plans covering only a single employee").

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[4] In response to *South-Eastern Underwriters*, Congress enacted the McCarran-Ferguson Act, which provides that state laws regulating insurance will not be "invalidate[d], impair[ed], or supersede[d]" by federal law, unless the federal law "specifically relates to the business of insurance." 15 U.S.C. § 1012(b). But this enactment in no way affects or diminishes the Court's clear holding in *South-Eastern Underwriters* that Congress may, concurrently with the states, regulate the business of insurance under the Commerce Clause. What's more, Congress has hardly abdicated its role in regulating the insurance business. *See Humana Inc. v. Forsyth*, 525 U.S. 299, 311, 314 (1999) (holding that federal RICO statute—which is itself grounded in the Commerce Clause—may be applied to insurers because it is not precluded by the McCarran-Ferguson Act); *id.* at 308 ("We reject any suggestion that Congress intended to cede the field of insurance regulation to the States . . . ."). Rather, the McCarran-Ferguson Act sought "to protect state regulation primarily against *inadvertent* federal intrusion—say, through enactment of a federal statute that describes an affected activity in broad, general terms, of which the insurance business happens to constitute one part." *Barnett Bank of Marion Cnty., N.A. v. Nelson*, 517 U.S. 25, 39 (1996).

Congressional efforts to regulate health insurance did not end with ERISA. Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. No. 99-272, 100 Stat. 82 (1986), which contains a wide variety of provisions relating to health care and health insurance. As for health insurance, the most significant reforms were amendments to ERISA, which added "continuation coverage" provisions that allow employees to continue receiving employer-sponsored health insurance for a period following the end of their employment in order to prevent gaps in health insurance coverage. 29 U.S.C. §§ 1161, 1162. And in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (1996), Congress amended the Public Health Service Act to add insurance portability provisions that prohibit group health plans—including ERISA plans—from discriminating against individual participants and beneficiaries based on health status, that require insurers to offer coverage to small businesses, and that limit pre-existing condition exclusions. *See* 29 U.S.C. §§ 1181-1183.

Under its commerce power, Congress has also repeatedly regulated the content of private health insurers' policies. *See, e.g.*, Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 702, 110 Stat. 2874, 2944 (1996) (regulating limits on mental health benefits); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 603, 110 Stat.

2874, 2935 (1996) (requiring maternity coverage to provide at least a 48-hour hospital stay); Women's Health and Cancer Rights Act of 1998, Pub. L. No. 105-277, § 902, 112 Stat. 2681, 2681-436 (1998) (requiring certain plans to offer benefits related to mastectomies); Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3765, 3881 (2008) (providing for parity between mental health/substance abuse disorder benefits and medical/surgical benefits).

Third, it is equally clear that Congress' power under the Commerce Clause likewise extends to the regulation of the provision and consumption of health care services. Indeed, for many years, Congress has substantially regulated both health care providers and the commodities that those providers may use. As far back as 1946, Congress enacted the Hospital Survey and Construction Act (also known as the "Hill-Burton Act"), Pub. L. No. 79-725, 60 Stat. 1040 (1946), which appropriated funds for the construction of new hospitals in the post-World War II economy. The Hill-Burton Act required hospitals receiving federal construction or renovation funds to provide care to "all persons residing in the territorial area" and to provide a "reasonable volume" of free care to indigent patients. *See* 42 U.S.C. § 291c(e).

The requirement that hospitals provide free care was strengthened and broadened, when, as part of COBRA, Congress enacted the Emergency Medical Treatment and Active Labor Act ("EMTALA"). COBRA, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164 (1986). EMTALA requires all hospitals that receive Medicare funds to screen and stabilize, if possible, any patient who comes in with an "emergency medical condition." 42 U.S.C. § 1395dd(a)-(b); *see also Roberts v.Galen of Va., Inc.*, 525 U.S. 249, 250-51 (1999) (per curiam). EMTALA also restricts the ability of hospitals to transfer a patient until he is stable or a medical determination is made that transfer is necessary. 42 U.S.C. § 1395dd(c). EMTALA's provisions are backed by both civil fines and a private cause of action for those harmed by a hospital's failure to comply. *Id.* § 1395dd(d).

Congress has also regulated health care providers (and, as mentioned, health care insurers) through HIPAA. The definition of "health care provider" under HIPAA is extraordinarily broad, covering any "person or organization who furnishes, bills, or is paid for health care in the normal course of business." 45 C.F.R. § 160.103. And in 2009, Congress expanded HIPAA's coverage even further to include "business associates" of health care providers and health insurers. *See* Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, §§ 13401, 13404, 123 Stat. 115, 260, 264 (2009); 45 C.F.R. § 160.103. In addition to the insurance portability provisions, HIPAA includes a number of privacy provisions that "govern[] the use and disclosure of protected health information" by health care providers and health insurers, *Sneed v. Pan Am. Hosp.*, 370 F. App'x 47, 50 (11th Cir. 2010) (per curiam) (unpublished), as well as protect the privacy of employees' health information against inquiries by their employers. HIPAA even regulates what information health care providers may communicate to one another. *See generally* 45 C.F.R. §§ 164.102-164.534; 42 U.S.C. § 1320d-2. HIPAA also requires health care providers to follow several administrative requirements, including the development of physical and technical privacy safeguards and employee training. *See* 45 C.F.R. §§ 164.308, 164.310, 164.312.

Fourth, Congress has extensively regulated under its commerce power the commodities used in the health care services market, most notably drugs and medical devices. For example, in the Food, Drug, and Cosmetics Act, Congress delegated to the Food and Drug Administration the authority to screen and approve drugs and medical devices for use in commerce, and to regulate their continued use once approved. *See, e.g.*, 21 U.S.C. §§ 351, 352, 355(a), 360c, 360e, 360j(e).

Fifth, the majority and all the parties also agree that Congress' commerce power extends to the regulation of the *price* to be paid for the consumption of health care services. Medicare is the most pervasive example. Since 1983, the Medicare program has set the fees it pays to hospitals through a prospective payment system that assigns a fixed amount to each service provided rather than reimbursing hospitals for their actual costs. *See United States v. Whiteside*, 285 F.3d 1345, 1346 (11th Cir. 2002). In 1989, Congress also set a federally determined fee schedule for Medicare payments to physicians. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239,

§ 6102, 103 Stat. 2106, 2169 (1989). In this way, Congress directly sets the prices for health care services paid for under Medicare.[5]

Beyond Congress' already substantial regulation of the price of health care services through Medicare and Medicaid, under controlling precedent Congress may lawfully regulate prices for all manner of health care consumption, however wise or unwise that regulation may be. In fact, the Supreme Court has said that Congress may regulate or even fix prices in interstate markets, either directly or by engaging in the "stimulation of commerce" through regulation. *Wickard v. Filburn*, 317 U.S. 111, 128 (1942) ("It is well established . . . that the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices."); *accord Gonzales v. Raich*, 545 U.S. 1, 18-19 (2005); *see also Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S.

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[5] While Medicaid prices are not as directly regulated at the federal level, Congress has legislated in a number of ways that affect the prices to be paid to health care providers and others under the Medicaid program. Most notable is the Medicaid Drug Rebate Program, created by the Omnibus Budget Reconciliation Act of 1990. The program provides that, if drug companies want their products to be covered by Medicaid, they must provide detailed price information to, and enter into a national rebate agreement with, the Secretary of HHS. 42 U.S.C. § 1396r-8. Congress has thus regulated prescription drug prices under Medicaid by requiring drug companies to provide discounts to states—in the form of rebates—for their Medicaid drug purchases. *See generally Iowa Dep't of Human Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 576 F.3d 885, 886-87 (8th Cir. 2009).

381, 394 (1940) (holding that Congress could not only regulate price, but could also attach "other conditions to the flow of a commodity in interstate [commerce]"); *id.* ("To regulate the price for . . . transactions is to regulate commerce itself, and not alone its antecedent conditions or its ultimate consequences." (quoting *Carter v. Carter Coal Co.*, 298 U.S. 238, 326 (1936) (Cardozo, J., dissenting in part and concurring in the judgment in part))).

Sixth, and perhaps most significantly, Congress' commerce power includes the power to prescribe rules cutting across the two linked markets of health insurance and health care services. Both the congressional intent to link the two and the empirical relation between the purchase of health insurance and the consumption of health care services are clear. Accordingly, in determining whether Congress has lawfully exercised its commerce power, courts must examine "the entire transaction, of which [the] contract [for insurance] is but a part, in order to determine whether there may be a chain of events which becomes interstate commerce." *South-Eastern Underwriters*, 322 U.S. at 547. I am hard pressed to *see* how the relevant "chain of events" here does not include the substantial consumption of health care services by the uninsured.

2.

The plaintiffs assert, nevertheless, that in enacting the individual mandate Congress was limited to regulating a single industry at a single point in time—in other words, it could only look at the health insurance market standing alone. In the plaintiffs' view, Congress could not mandate the purchase of insurance as a means of ameliorating a national problem arising in the related but distinct market for health care services. The majority appears to have adopted this view, concluding that the relevant conduct targeted by Congress is not the uncompensated consumption of health care services by the uninsured, but rather only the decision to forego health insurance. Maj. Op. at 126, 136. This approach is wooden, formalistic, and myopic. The plaintiffs and the majority would view the uninsured in a freeze-framed still, captured, like a photograph, in a single moment in time. They contend that Congress cannot constitutionally regulate the uninsured as a class at that single moment, because at that moment any particular uninsured individual may be healthy, may be sitting in his living room, or may be doing nothing at all. The only way the plaintiffs and the majority can round even the first base of their argument against the mandate is by excluding from Congress' purview, for no principled reason that I can discern, the cost-shifting problems that arise in the health care services market.

This blinkered approach cannot readily be squared with the well-settled principle that, in reviewing whether Congress has acted within its enumerated powers, courts must look at the nature of the problem Congress sought to address, based on economic and practical realities. *See Swift & Co.*, 196 U.S. at 398 ("[C]ommerce among the states is not a technical legal conception, but a practical one, drawn from the course of business."); *Wickard*, 317 U.S. at 123-24 ("[R]ecognition of the relevance of the economic effects in the application of the Commerce

Clause . . . has made the mechanical application of legal formulas no longer feasible."); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 41-42 (1937) (observing that "interstate commerce itself is a practical conception"); *N. Am. Co. v. SEC*, 327 U.S. 686, 705 (1946) ("Congress is not bound by technical legal conceptions. Commerce itself is an intensely practical matter. To deal with it effectively, Congress must be able to act in terms of economic and financial realities." (citation omitted)); *Lopez*, 514 U.S. at 571, 574 (Kennedy, J., concurring) (favoring a pragmatic approach to Congress' commerce power grounded in "broad principles of economic practicality" and a "practical conception of commercial regulation"); *Raich*, 545 U.S. at 25 n.35. When the individual mandate is viewed through a more pragmatic and less stilted lens, it is clear that Congress has addressed a substantial economic problem: the uninsured get sick or injured, seek health care services they cannot afford, and shift these unpaid costs onto others.

Moreover, despite their contention that Congress is limited to regulating in a single industry, the plaintiffs nevertheless concede that Congress may use its rule-making power to regulate the *market for health insurance* as a vehicle or means to address the cost-shifting problems arising in the *market for health care services*. They have conceded, both in their briefs and at oral argument, that Congress may constitutionally regulate the consumption of health care services by the uninsured at the *time* they actually seek medical care. The plaintiffs acknowledge—as does the majority—that Congress may constitutionally require the uninsured to obtain health care insurance on the hospital doorstep, or that Congress may otherwise impose a penalty on those who attempt to consume health care services without insurance. States Br. at 31-32 ("Supreme Court precedent allows Congress to regulate [the practice of consuming health care services without insurance]—for example, by imposing restrictions or penalties on individuals who attempt to consume health care services without insurance."); Maj. Op. at 129-30 ("[W]hen the uninsured actually enter the stream of commerce and consume health care, Congress may regulate their activity at the point of consumption."); *see also Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683, at *26 (N.D. Fla. Jan. 31, 2011) ("Congress plainly has the power to regulate [the uninsured] . . . at the time that they initially seek medical care[], a fact with which the plaintiffs agree.").[6] Thus, all of the parties agree that, at the time of health care consumption, Congress may lawfully cut across a distinct market and impose a financial penalty designed to compel the uninsured to obtain health insurance. And Congress may do so even where the uninsured would otherwise voluntarily choose to finance the consumption of health care services out of pocket, without buying insurance.

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[6] At oral argument, counsel for the state plaintiffs was explicitly asked whether, at the point of health care consumption, Congress "could compel an individual who doesn't have health insurance to either pay a penalty or obtain insurance at that time," to which counsel responded that "[i]n the health care market, at the time of consumption, yes." And at the district court hearing on the government's motion to dismiss, counsel for the plaintiffs made a similar concession. In response to the district court's question, "Well, the government could impose this penalty at the point of service at the doctor's office or the hospital and say, if you do not have insurance, you are subject to a penalty?," counsel for the plaintiffs responded, "I believe the government would be able to do it, Your Honor." RE 334-35.

If the plaintiffs had argued that Congress cannot constitutionally force anyone to buy health insurance at any time as a means of paying for health care, they at least would have evinced the virtue of consistency. But instead, the plaintiffs' concession undermines their claim that Congress has exceeded its rulemaking power by regulating in one industry to address a problem found in another, at least where the two industries are so closely bound together. After all, even at the point of consuming *health care services*, individuals may wish to remain "inactive" in the *health insurance* market. But the plaintiffs and the majority concede that Congress may nevertheless compel individuals at that point to purchase a private insurance product.

Despite this concession, the plaintiffs contend that the regulation of commerce necessarily presupposes a pre-existing voluntary activity to be regulated. The plaintiffs' activity/inactivity dichotomy, however, is nowhere to be found in the text of the Commerce Clause, nor in the jurisprudence surrounding it. The language of the Commerce Clause itself draws no distinction between activity and inactivity. The seven operative words speak broadly about Congress' power "[t]o regulate Commerce . . . among the several States." U.S. CONST. art. I, § 8, cl. 3. The power to regulate is the power "to prescribe the rule by which commerce is to be governed." *Gibbons*, 22 U.S. at 196. And while the power of Congress is limited to specific objects, it is "plenary as to those objects." *Id.* at 197. Creating an artificial doctrinal distinction between activity and inactivity is thus novel and unprecedented, resembling the categorical limits on Congress' commerce power the Supreme Court swept away long ago.

The plaintiffs claim, nevertheless, that the individual mandate exceeds Congress' commerce power because it improperly conscripts uninsured individuals—who are presently *inactive* in the health *insurance* market—to unwillingly enter the stream of commerce to purchase health insurance they would not otherwise choose to buy. The plaintiffs and the majority would have Congress wait at the water's edge until the uninsured literally enter the emergency room. In other words, they say, Congress may not legislate prophylactically, but instead must wait until the cost-shifting problem has boiled over, causing huge increases in costs for those who have health care insurance (through increased premiums), and for those who provide health care services.

At bottom, the plaintiffs' argument seems to boil down only to a temporal question: can Congress, under the Commerce Clause, regulate how and when health care services are paid for by requiring individuals—virtually all of whom will consume health care services and most of whom have done so already—to pay *now* for those services through the mechanism of health insurance? As I see it, the answer to whether Congress can make this temporal jump under its Commerce Clause power is yes.

There is no doctrinal basis for requiring Congress to wait until the cost-shifting problem materializes for each uninsured person before it may regulate the uninsured as a class. The majority's imposition of a strict temporal requirement that congressional regulation only apply to individuals who first engage in specific market transactions in the health care services market is at war with the idea that Congress may adopt "reasonable preventive measures" to avoid *future* disruptions of interstate commerce. *Consol. Edison Co. v. NLRB*, 305 U.S. 197, 222 (1938) ("[I]t cannot be maintained that the exertion of federal power must await the disruption of [interstate or foreign] commerce."); *see also Katzenbach v. McClung*, 379 U.S. 294, 301 (1964) (quoting same, and noting that "Congress was not required to await the total dislocation of commerce"); *Stevens v. United States*, 440 F.2d 144, 152 (6th Cir. 1971) ("It is not necessary for Congress to await the total dislocation of commerce before it may provide reasonable preventive measures for the protection of commerce." (citing *Katzenbach*, 379 U.S. at 301)), *limited on other grounds by United States v. Bass*, 404 U.S. 336 (1971); *NLRB v. Sunshine Mining Co.*, 110 F.2d 780, 784 (9th Cir. 1940). In *Consolidated Edison*, the Supreme Court explained that, through the National Labor Relations Act—which regulates labor practices—"Congress did not attempt to deal with particular instances" in which interstate commerce was disrupted, concluding that Congress did not need to wait until labor practices actually disrupted interstate commerce before it could regulate.[7] 305 U.S. at 222. In other words, Congress may lawfully regulate present conduct to prevent future disruptions of interstate commerce from occurring.

What's more, and even more basic, here the disruption of interstate commerce is *already* occurring. The majority inexplicably claims that the individual mandate regulates "the mere *possibility* of *future* activity," Maj. Op. at 129, but as we speak, the uninsured are consuming health care services in large numbers and shifting costs onto others. By ignoring the close relationship between the health insurance and health care services markets, the plaintiffs and the majority seek to avoid the hard fact that the uninsured as a class are actively consuming substantial quantities of health care services *now*—not just next week, next month, or next year. The uninsured make more than 20 million visits to emergency rooms each year; 68% of the uninsured had routine checkups in the past five years; and 50% had one in the past two years.[8] *See* U.S. Dep't of HHS, New Data Say Uninsured Account for Nearly One-Fifth of Emergency Room Visits (July 15, 2009), *available at* http://www.hhs.gov/news/press/2009pres/07/20090715b.html; June E. O'Neill & Dave M. O'Neill, Emp't Policies Inst., Who Are the Uninsured? An Analysis of America's Uninsured Population, Their Characteristics and Their Health 20-21 & tbl.9 (2009), *available at* http://epionline.org/studies/oneill_06-2009.pdf; *see also* Hidden Health Tax, *supra*, at 2 (observing that the uninsured consumed $116 billion worth of health care services in 2008); Gov't Econ. Br. at 10 ("57 percent of the 40 million people uninsured in all of 2007 used medical services *that year*." (emphasis added)); NFIB Br. at 5 (citing same 57% statistic). In addition, there were more than two million hospitalizations—not just emergency room visits, but actual admissions to a hospital—of the uninsured in 2008 alone. U.S. Dep't of HHS, ASPE Research Brief, The Value of Health Insurance: Few of the Uninsured Have Adequate Resources To Pay Potential Hospital Bills 5 (2011), *available at* http://aspe.hhs.gov/health/reports/2011/valueofinsurance/rb.pdf.

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[7] The majority opinion misapprehends this point. *See* Maj. Op. at 129 n.100. *Consolidated Edison* is cited along with *Katzenbach* to make this simple point: Congress need not wait until an economic problem has erupted and the national economy is disrupted before it may act prophylactically, under its commerce power, to address an obvious and apparent economic problem. That *Consolidated Edison* specifically involved the regulation of labor practices or that *Katzenbach* (along with *Heart of Atlanta*) specifically involved the regulation of innkeepers and restaurateurs is beside the point. This principle of Commerce Clause jurisprudence is general, and it remains binding law.

In light of these undisputed figures, there can be little question that substantial numbers of uninsured Americans are currently active participants in the health care services market, and that many of these uninsured currently consume health care services for which they cannot or do not pay. This is, in every real and meaningful sense, classic economic *activity*, which, as Congress' findings tell us, has a profound effect on commerce. *See Thomas More Law Ctr. v. Obama*, __ F.3d __, 2011 WL 2556039, at *24 (6th Cir. June 29, 2011) (Sutton, J., concurring) ("No matter how you slice the relevant market—as obtaining health care, as paying for health care, as insuring for health care—all of these activities affect interstate commerce, in a substantial way.").[9] Once the artificial barrier drawn between the health insurance and health care services markets breaks down, the plaintiffs' inactivity argument collapses. And there can be no doubt that Congress rationally linked the two markets. Its very findings accompanying the mandate detail at length the impact that going uninsured has on the broader availability of health insurance *and* on the costs associated with the consumption of health care services. *See* 42 U.S.C. § 18091(a)(2). I observe again that "[h]ealth insurance is purchased not as a final consumption good but as a means of paying for the future stochastic purchase of health care services." Welfare Loss, *supra*, at 253. And virtually all of us will have the misfortune of having to consume health care services at some unknown point for some unknown malady and at some uncertain price. Each of us remains susceptible to sudden and unpredictable injury. No one can opt out of illness, disability, and death. These, we all must accept, are facts of life. Thus, even if I were to accept the plaintiffs' distinction between activity and inactivity, the facts undermine the distinction here. The inevitable consumption of health care services by the uninsured is sufficient activity to subject them to congressional regulation.

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[8] The plaintiffs do not contest the validity of these data. Indeed, at oral argument, counsel for the state plaintiffs conceded that these visits to the emergency room constitute economic activity that Congress may lawfully regulate.

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[9] Contrary to the majority's assertion, *see* Maj. Op. at 147 n.119, the conduct being regulated by Congress is the *consumption* of health care services by the uninsured. And it is the very act of consuming health care services by those who do not pay for them that has the natural and probable effect of shifting costs to those who do—what occurs when I consume a good, and leave you with the bill. In every real sense, the *conduct* being regulated is analytically and conceptually distinct from its *effects* on interstate commerce.

3.

The plaintiffs and the majority also object to the mandate on different grounds—that it is "overinclusive" insofar as it applies to: "those who do not enter the health care market at all" ("non-consumers"), and those who consume health care services but pay for their services in full and thus do not shift costs ("non-cost-shifters"). Maj. Op. at 127.

The majority understates the point when it acknowledges that "overinclusiveness may not be fatal for constitutional purposes." *Id.* Indeed, the Supreme Court has made it abundantly clear that Congress is not required to "legislate with scientific exactitude." *Raich*, 545 U.S. at 17. Rather, "[w]hen Congress decides that the *total incidence* of a practice poses a threat to a national market, it may regulate the *entire class*." *Id.* (emphases added) (internal quotation marks omitted). As Justice

Holmes put it in *Westfall v. United States*, 274 U.S. 256 (1927), "when it is necessary in order to prevent an evil to make the law embrace more than the precise thing to be prevented [Congress] may do so." *Id.* at 259. There is simply no requirement under the Commerce Clause that Congress choose the least restrictive means at its disposal to accomplish its legitimate objectives. Nor is there a requirement that Congress target only those uninsured individuals who will consume health care services at a particular point in time or just those who will be unable to pay for the health care services they consume. Congress concluded that the "total incidence" of health care consumption by the uninsured threatened the *national* health insurance and health care services markets. It was free to regulate the "entire class" of the uninsured.[10]

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[10] The Court in *Raich* specifically approved of Congress' legislating across a broad class when "enforcement difficulties" would attend drawing the class more narrowly. *Raich*, 545 U.S. at 22. The Court said, "[g]iven the enforcement difficulties that attend distinguishing between marijuana cultivated locally and marijuana grown elsewhere, and concerns about diversion into illicit channels, we have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a gaping hole in the CSA." *Id.* (citation and footnote omitted). When it may be difficult to distinguish between categories of conduct, especially when the categories are fluid, Congress may enlarge the regulated class. Here, too, Congress may broadly regulate uninsured individuals because it may be difficult to distinguish between cost-shifters and non-cost-shifters. And the categories are fluid—a non-consumer or non-cost-shifter today may become a cost-shifter tomorrow, especially if a catastrophic injury befalls him. Moreover, the

Moreover, even if I were to accept the notion that Congress, in regulating commerce, was obliged to somehow draw the class more narrowly, the subclass of "non-consumers"—those individuals who will never enter the health care services market at all—is surely minuscule. The plaintiffs emphasize that it is "not strictly true" that everyone will participate in the health care services market. States Br. At 30. But the only elaboration the plaintiffs offer on this point is that some individuals will not participate because of "religious scruples" or the vaguely-put "individual circumstances." *Id.* As for the first, it does not get the plaintiffs very far, because religious groups that opt out of the health care services or health insurance markets may also seek exemption from the individual mandate. 26 U.S.C. § 5000A(d)(2). And as for "individual circumstances," presumably what the plaintiffs mean is that a few individuals either will fortuitously avoid ill health altogether, or—more likely—will fail to consume health care services due to an immediately fatal accident or the like. I am unable to draw a relevant constitutional distinction between the *virtual* inevitability of health care consumption and the absolute, 100% inevitability of health care consumption. There is less of a chance that an individual will go through his entire life without ever

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majority concedes that Congress may regulate *all* of the uninsured—cost-shifters and non-cost-shifters alike—at the point of consumption. *See* Maj. Op. at 129-30. Thus, by the majority's own lights, Congress' inclusion of non-cost-shifters within the mandate's reach does not create a constitutional infirmity.

consuming health care services than there is that he will win the Irish Sweepstakes at the very moment he is struck by lightning. Nor are there more than a minuscule number of Americans who could afford to take on the financial risk of a personal medical catastrophe out of their own pockets. Yet, on the basis of these slight mathematical possibilities would the majority bring down the individual mandate and all that may fall with it.

Congress has wide regulatory latitude to address "the extent of financial risk-taking in the health care services market," Gov't Reply Br. at 15, which in its view is "a threat to a national market," *Raich*, 545 U.S. at 17. The fact that an exceedingly small set of individuals may go their whole lives without consuming health care services or can afford to go it alone poses no obstacle to Congress' ability under the Commerce Clause to regulate the uninsured as a class.

Similarly, a group of economists who filed an amicus brief in support of the plaintiffs object to the individual mandate by disputing the substantiality of the cost-shifting impact the mandate seeks to address. First, they claim that the individual mandate targets the young and healthy and that the annual costs of uncompensated care for *those* individuals is much less than $43 billion. *See* Brief for Economists as *Amici Curiae* Supporting the Plaintiffs ("Plaintiffs Econ. Br.") at 3, 10, 13. The point is unpersuasive, because it conflates the scope of the individual mandate with its relative benefits for different population groups. The individual mandate applies to all non-exempted individuals, 26 U.S.C. § 5000A(a), and while the young and healthy may benefit less than other groups from having health insurance, "[i]t is of the essence of regulation that it lays a restraining hand on the self-interest of the regulated and that advantages from the regulation commonly fall to others," *Wickard*, 317 U.S. at 129. Balancing different groups' competing economic interests is not a constitutional concern for the courts to calibrate, but rather is "wisely left under our system to resolution by the Congress under its more flexible and responsible legislative process." *Id.* Moreover, the argument that the mandate targets the young and healthy and that, therefore, this Court should only look at the economic impact on interstate commerce of *those* individuals is not even consistent with the plaintiffs' own suggestion that the individual mandate regulates "*everyone* at *every* moment of their lives, from cradle to grave." States Br. at 29.

The economists also suggest that even if we look at the $43 billion figure as a whole, that amount is less than 1.8% of overall annual health care spending (which Congress found was $2.5 trillion, or 17.6% of the national economy, in 2009, 42 U.S.C. § 18091(a)(2)(B)), and, therefore, the "alleged cost-shifting problem" is relatively modest and fails to justify the individual mandate. Plaintiffs Econ. Br. at 9-10. The argument is unconvincing. It would be novel indeed to examine whether a problem "substantially affects" interstate commerce by comparing the economic impact of the problem to the total size of the regulated market. The argument would also lead to the perverse conclusion that Congress has *less* regulatory power the larger the national market at issue. But in any event, there can be no doubt that $43 billion is a substantial amount by any accounting. Even the economists (as well as the district court) recognize that the amount is "not insignificant." Plaintiffs Econ. Br. at 10; *accord Florida*, 2011 WL 285683, at *26 (noting that $43 billion "is clearly a large amount of money"). In this connection, I am reminded of the comment often attributed to the late Illinois Senator Everett McKinley Dirksen: "A billion here, a billion there, and pretty soon you're talking about real money."

Relying heavily on the economists' brief, the majority goes even further and subjects Congress' findings to an analysis that looks startlingly like strict scrutiny review. The majority engages in a breakdown of who among the uninsured are responsible for the $43 billion, presumably in order to show that the mandate will not be the most efficacious means of ameliorating the cost-shifting problem. *See* Maj. Op. at 139-41. For instance, the majority claims that low-income individuals and illegal aliens (or other nonresidents) together are responsible for around half of the total cost shifting, yet are exempted from either the mandate or its penalty. *Id.* at 139-40. But even on the majority's own terms, a substantial number of cost-shifters are *not* exempted from the mandate or its penalty, and there was nothing irrational about Congress' decision to subject to the mandate those individuals who could reasonably afford health insurance in the first place.

More fundamentally, however, as I see it, the majority's searching inquiry throughout its opinion into whether the individual mandate fully solves the problems Congress aimed to solve, or whether there may have been more efficacious ways to do so, probes far beyond the proper scope of a court's Commerce Clause review. The majority suggests any number of changes to the legislation that would, it claims, improve it. Thus, for example, the majority offers that Congress should have legislated with a finer scalpel by inserting some element in the statute calling for a "case-by-case inquiry" of each regulated individual's conduct. *Id.* at 128 (internal quotation marks omitted). And the majority would have the IRS enforce the mandate more aggressively. *See id.* at 166; *id.* at 202 (describing the mandate as "porous and toothless").

Quite simply, the majority would presume to sit as a superlegislature, offering ways in which Congress could have legislated more efficaciously or more narrowly. This approach ignores the wide regulatory latitude afforded to Congress, under its Commerce Clause power, to address what *in its view* are substantial problems, and it misapprehends the role of a reviewing court. As nonelected judicial officers, we are not afforded the opportunity to rewrite statutes we don't like, or to craft a legislative response more sharply than the legislative branch of government has chosen. What we are obliged to do is to determine whether the congressional enactment falls within the boundaries of Art. 1, § 8, cl. 3. In examining the constitutionality of legislation grounded in Congress' commerce power, "[w]e need not determine whether [the regulated] activities, taken in the aggregate, substantially affect interstate commerce *in fact*." *Raich*, 545 U.S. at 22 (emphasis added). Rather, all we need to do—indeed, all we are *permitted* to do—is determine "whether a 'rational basis' exists for so concluding." *Id.* The courts are not called upon to judge the wisdom or efficacy of the challenged statutory scheme. *See, e.g., id.* at 9 ("The question before us, however, is not whether it is wise to enforce the statute in these circumstances."); *Wickard*, 317 U.S. at 129 ("And with the wisdom, workability, or fairness[] of the plan of regulation we have nothing to do."). As Justice Cardozo put it, "[w]hether wisdom or unwisdom resides in the scheme of [the statute at issue], it is not for us to say. The answer to such inquiries must come from Congress, not the courts." *Helvering v. Davis*, 301 U.S. 619, 644 (1937); *see also Thomas More Law Ctr.*, 2011 WL 2556039, at *33 (Sutton, J., concurring) ("Time assuredly will bring to light the policy strengths and weaknesses of using the individual mandate as part of this national legislation, allowing the peoples' political representatives, *rather than their judges*, to have the primary say over its utility." (emphasis added)).

The majority says, nevertheless, that we are compelled to approach the individual mandate with "caution" and with "greater cause for doubt," Maj. Op. at 152, because insurance and health care are "areas of traditional state concern," *id.* at 150. While it is true that insurance and health care are, generally speaking, areas of traditional state regulation, this observation in no way undermines Congress' commerce power to regulate concurrently in these areas. The sheer size of the programs Congress has created underscores the extensiveness of its regulation of the health insurance and health care industries. "In 2010, 47.5 million people were covered by Medicare . . . ." 2011 Annual Report of the

Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 4 (2011), *available at* http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf. Medicaid is similarly massive. As of December 2008, approximately 44.8 million people were covered by Medicaid. The Kaiser Commission on Medicaid and the Uninsured, Medicaid Enrollment in 50 States 1 (2010), *available at* http://www.kff.org/medicaid/upload/7606-05.pdf. And as the government points out, Medicare and Medicaid accounted for roughly $750 billion of federal spending in 2009 alone. Gov't Br. at 10. It would surely come as a great shock to Congress, or, for that matter, to the 47.5 million people covered by Medicare, the 44.8 million people covered by Medicaid, and the overwhelming number of employers, health insurers, and health care providers regulated by ERISA, COBRA, and HIPAA, to learn that, because the health care industry also "falls within the sphere of traditional state regulation," Maj. Op. at 153, Congress was somehow skating on thin constitutional ice when it enacted these laws.

4.

In the course of its opinion, the majority also attaches great significance to the unprecedented nature of the legislation before us. It is surely true that, as the district court concluded, the individual mandate is a novel exercise of Congress' Commerce Clause power. *Florida*, 2011 WL 285683, at *20-21. But the mere fact of its novelty does not yield its unconstitutionality. *See Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1252 (11th Cir. 2008) (upholding, under the Commerce and

Necessary and Proper Clauses, the constitutionality of the Graves Amendment, 49 U.S.C. § 30106, even though it was a "novel" statute employing the "relatively novel" theory that the rental car market should be protected "by deregulating it"). Every new proposal is in some way unprecedented before it is tried. And to draw the line against any new congressional enactment simply because of its novelty ignores the lessons found in the Supreme Court's Commerce Clause cases. For example, in *Wickard* the Court squarely recognized that the case presented an unprecedented expansion of the Commerce Clause power before then embracing that expansion. 317 U.S. at 120 ("Even today, when this power has been held to have great latitude, there is no decision of this Court that such activities ["local" activities such as production, manufacturing, and mining] may be regulated where no part of the product is intended for interstate commerce or intermingled with the subjects thereof."). The truth is that any ruling this Court issues on the individual mandate's constitutionality is necessarily a departure from existing case law because the legislation and the issues presented are new. That the Supreme Court has never before upheld a regulation of this kind can hardly be decisive; it has never rejected one either.

Indeed, when measured against the kinds of sweeping changes we have seen in the past, the individual mandate is far from a cataclysmic expansion of Congress' commerce power. Even the briefest examination of the growth of Congress' commerce power over the past 75 years makes the point. Facing the practical realities of an emergent, highly integrated national economy, the Supreme Court abandoned the categorical and formalistic distinctions that it had erected initially, in favor of a pragmatic view of commerce drawn from the course of business. The Court had previously held that broad categories of economic life, such as agriculture, insurance, labor, manufacturing, mining, and production were *antecedent* to commerce itself, which was once viewed as being limited to the *movement* of the fruits of those antecedent activities in and among the states. But a more pragmatic view began to take hold by the mid-1930s. The Court's earlier restrictive view of commerce did not survive the New Deal-era cases, where the Supreme Court swiftly brought all of these categories within the lawful ambit of Congress' commerce power. *See, e.g.*, *Jones & Laughlin Steel*, 301 U.S. at 40 ("It is thus apparent that the fact that the employees here concerned were engaged in production is not determinative. The question remains as to the effect upon interstate commerce of the labor practice involved."); *United States v. Darby*, 312 U.S. 100, 115-17 (1941) ("[W]e conclude that the prohibition of the shipment interstate of goods produced under the forbidden substandard labor conditions is within the constitutional authority of Congress."); *Wickard*, 317 U.S. at 124-25 ("Whether the subject of the regulation in question was 'production,' 'consumption,' or 'marketing' [of wheat] is . . . not material for purposes of deciding the question of federal power before us. . . . [E]ven if appellee's activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce . . . ."); *South-Eastern Underwriters*, 322 U.S. at 553 ("No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.").

The Court did not stop there. It expanded the scope of Congress' commerce power from the regulation of the "intercourse" of goods moving across borders to the regulation of wholly *intrastate* conduct that substantially affected interstate commerce. *See Darby*, 312 U.S. at 119-20 & n.3. Indeed, *Wickard* involved a jump arguably far greater than the one we face today. In order to regulate price, Congress could penalize conduct—Filburn's growing wheat above a fixed quota for his own personal consumption—absent *any* indicia that Filburn would *ever* enter into the interstate wheat market. Justice Jackson, writing for the Court, recognized this as a novel exercise of the commerce power. *Wickard*, 317 U.S. at 120. The Court held that Congress could nonetheless regulate the price of wheat by restricting its production, even on a small farm where it was grown purely for personal consumption. And, according to the Court, if the regulation had the natural and probable effect of "*forcing* some farmers into the market to buy what they could provide for themselves" absent the regulation, so be it. *Id.* at 129 (emphasis added).

In *Wickard*, the Court expanded Congress' commerce power further still, concluding that the impact or effect on interstate commerce is not measured case by case, or person by person, but rather in an *aggregated* way. *Id.* at 127-28. That Filburn's "own contribution to the demand for wheat may be trivial by itself is not enough to remove him from the scope of federal regulation where, as here, his contribution, *taken together with that of many others similarly situated*, is far from trivial." *Id.* (emphasis added); *see also Darby*, 312 U.S. at 123 ("[Congress] recognized that in present day industry, competition by a small part may affect the whole and that the total effect of the competition of many small producers may be great."); *NLRB v. Fainblatt*, 306 U.S. 601, 606 (1939) ("The power of Congress to regulate interstate commerce is plenary and extends to all such commerce be it great or small."). Building upon earlier inklings of an aggregation principle found in *Darby* and *Fainblatt*, the Court firmly established that Congress may regulate classes of local activities that, only in the aggregate, have a substantial effect on interstate commerce.[11]

In a pair of notable civil rights cases, *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241 (1964), and *Katzenbach*, 379 U.S. 294, the Supreme Court continued to read the Commerce Clause in an expansive way. The Court upheld nondiscrimination legislation, grounded in the Commerce Clause, that required hoteliers and restaurateurs to enter into economic transactions with racial minorities (indeed, with individuals of any race, color, religion, or national origin) on the same terms as any other patrons (or exit their respective businesses altogether). The Court underscored that "the power of Congress to promote interstate commerce also includes the power to regulate the local incidents thereof, including local activities in both the States of origin and destination, which might have a substantial and harmful effect upon that commerce." *Heart of Atlanta*, 379 U.S. at 258. The Court concluded that, having entered the stream of commerce, these sellers could be forced by Congress to engage in economic transactions into which they would not otherwise enter.

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[11] The majority attempts to skirt the breadth of the aggregation principle by claiming that an "individual's mere decision not to purchase insurance" is not subject to aggregation. Maj. Op. at 125. But again, the majority has shot at the wrong target. Congress is regulating the uninsured's uncompensated consumption of health care services. And under *Wickard* and *Raich*, we are instructed to measure the effect on interstate commerce not case-by-case or person-by-person, but rather in the aggregate and taken as a whole.

The plaintiffs are quick to point out, however, that the Commerce Clause has not simply expanded unabated. In rejecting the constitutionality of the individual mandate, the plaintiffs and the majority rely heavily upon *Lopez*, 514 U.S. 549, and *United States v. Morrison*, 529 U.S. 598 (2000), the only two Supreme Court cases in the past 75 years to hold that an act of Congress exceeded its commerce power. Neither *Lopez*, where the Court struck down a statute criminalizing the possession of a firearm within 1000 feet of a school, nor *Morrison*, where the Court struck down a statute creating a federal civil remedy for victims of gender-motivated felonious acts of violence, answers the question we face today.

Indeed, in *Raich*, 545 U.S. 1, decided five years after *Morrison*, the Supreme Court reaffirmed the vitality of *Wickard*, and specifically applied its holding in a challenge to the constitutionality of the Controlled Substances Act ("CSA"). The Court emphatically distinguished *Lopez* and *Morrison*, observing that the statutes at issue in those cases were singular prohibitions regulating wholly noneconomic criminal behavior. The CSA, on the other hand, was characterized as "a lengthy and detailed statute creating a comprehensive framework for regulating the production, distribution, and possession of five classes of 'controlled substances.'" *Raich*, 545 U.S. at 24. The Court found that, "[u]nlike those at issue in *Lopez* and *Morrison*, the activities regulated by the CSA are quintessentially economic." *Id.* at 25.

Thus, much as in *Raich*, while *Lopez* and *Morrison* remind us that there are discernible limits on Congress' commerce power, the limits drawn in those two cases are of limited help in this one. As a panel of this Circuit recently stated, "*Raich* makes clear that when a statute regulates economic or commercial activity, *Lopez* and *Morrison* are inapposite." *Garcia*, 540 F.3d at 1252. Indeed, when "we are not . . . dealing with a single-subject statute whose single subject is itself non-economic (*e.g.*, possession of a gun in a school zone or gender-motivated violence)," *Morrison* and *Lopez* have little applicability and instead "*Raich* guides our analysis." *United States v. Maxwell* ("*Maxwell II*"), 446 F.3d 1210, 1216 n.6 (11th Cir. 2006); *see also United States v. Paige*, 604 F.3d 1268, 1273 (11th Cir. 2010) (per curiam). *Lopez* and *Morrison* each involved an effort to regulate *noneconomic* activity (criminal conduct); in neither instance did Congress seek to broadly regulate an *entire* industry; and, unlike in this case, the criminal conduct regulated in those cases was only linked to interstate commerce in a highly attenuated fashion that required piling inference upon inference. Whatever problems there may be with the constitutionality of the individual mandate, they cannot be found in *Lopez* or *Morrison*. *See* Part II.A, *infra*.

The historical growth of Congress' commerce power powerfully suggests that, contrary to the arguments advanced by the plaintiffs, upholding the individual mandate would be far from a cosmic expansion of the boundaries of the Commerce Clause. These past expansions have not been random, accidental, or in any way contrary to first principles or an original understanding of the Constitution. As the Supreme Court has observed, "[t]he Federal Government undertakes activities today that would have been unimaginable to the Framers." *United States v. Comstock*, __ U.S. __ , 130 S. Ct. 1949, 1965 (2010) (quoting *New York v. United States*, 505 U.S. 144, 157 (1992)). Indeed, the Framers purposely drafted "a Constitution capable of such resilience through time." *Id.*; *see also McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 415 (1819) (describing the Constitution as a document "intended to endure for ages to come, and consequently, to be adapted to the various *crises* of human affairs").

The long and short of it is that Congress has promulgated a rule (the individual mandate) by which to comprehensively regulate the timing and means of payment for the virtually inevitable consumption of health care services, and to thereby regulate commerce. The individual mandate was enacted as part of a broad scheme to regulate health insurance and health care services, industries already heavily regulated by Congress. Congress made express legislative findings detailing the *economic* problems it saw, and how the mandate would ameliorate those problems. And the substantial impact on interstate commerce cannot be denied. Article 1, § 8, cl. 3 requires no more than this.

C.

The individual mandate is also a valid means under the Necessary and Proper Clause to further the regulatory end of the Act's insurance reforms. "It has been long recognized that Congress has the power to pass laws or regulations necessary and proper to carrying out [its] commerce clause power." *United States v. Ambert*, 561 F.3d 1202, 1211 (11th Cir. 2009). Under the Necessary and Proper Clause, Congress is empowered "[t]o make all Laws which shall be necessary and proper for carrying into Execution the foregoing [Art. 1, § 8] Powers." U.S. CONST. art. 1, § 8, cl. 18. Both the Supreme Court and this Circuit have said that "in determining whether the Necessary and Proper Clause grants Congress the legislative authority to enact a particular federal statute, we look to see whether the statute constitutes a means that is *rationally related* to the implementation of a constitutionally enumerated power." *Comstock*, 130 S. Ct. at 1956 (emphasis added); *United States v. Belfast*, 611 F.3d 783, 804 (11th Cir. 2010).

The constitutionality of the "end"—that is, the Act's insurer regulations—is both clear and unchallenged, as even the district court recognized. *Florida*, 2011 WL 285683, at *32 ("[T]he end of regulating the health care insurance industry (including preventing insurers from excluding or charging higher rates to people with preexisting conditions) is clearly legitimate and within the scope of the constitution." (internal quotation marks omitted)). Once it has identified a legitimate and constitutional end, Congress has an expansive choice of means. As Chief Justice Marshall enduringly articulated "[i]n language that has come to define the scope of the Necessary and Proper Clause," *Comstock*, 130 S. Ct. at 1956:

> Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.

McCulloch, 17 U.S. at 421. In addition, Chief Justice Marshall broadly defined the term "necessary." It does not mean "absolutely necessary," but rather only "convenient, or useful" or "conducive" to the "beneficial exercise" of one or more of Congress' enumerated powers. *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch*, 17 U.S. at 413, 414, 418).

It is clear under this expansive definition of "necessary," the validity of which was recently reaffirmed by the Supreme Court in *Comstock*, that requiring the purchase of health insurance is "convenient," "useful," or "conducive" to effectively implementing the Act's insurer regulations. As the states that tried to effectuate guaranteed issue and community rating reforms without some form of individual mandate attest, trying to do the former without the latter simply does not work. *See, e.g.*, Brief for Am. Ass'n of People with Disabilities et al. as *Amici Curiae* Supporting the Government at 5-6 ("Kentucky, Maine, New Hampshire, New Jersey, New York, Vermont, and Washington enacted legislation that required insurers to guarantee issue to all consumers in the individual market, but did not have a minimum coverage provision. . . . All seven states suffered from sky-rocketing insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers." (footnote omitted)); Brief for Governor of Wash. as *Amicus Curiae* Supporting the Government at 2 ("Washington knows firsthand the necessity of universal coverage because of the problems it experienced when it eliminated barriers to insurance coverage, like preexisting condition restrictions, without also imposing a minimum coverage requirement."); Brief for Law Professors as *Amici Curiae* Supporting the Government at 17 ("[A]fter Kentucky enacted reform, all but two insurers (one State-run) abandoned the State.").[12] In 12 this light, the individual mandate is "necessary" to the end of regulating insurers' underwriting practices without running insurers out of business entirely—a point the district court recognized. *Florida*, 2011 WL 285683, at *33 ("The defendants have asserted again and again that the individual mandate is absolutely 'necessary' and 'essential' for the Act to operate as it was intended by Congress. I accept that it is.").

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[12] During a hearing before the House Ways and Means Committee, an economist stated that "imposition of *community-rated premiums* and *guaranteed* issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with . . . a *mandate on individual[s] to be insured." Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. On Ways and Means*, 111th Cong. 13 (2009) (statement of Dr. Uwe Reinhardt, Professor, Princeton University). In other words, without a mandate, these two insurer reforms

The plaintiffs also claim that the individual mandate exceeds Congress' power because it is not "proper"—that is, because it is inconsistent with "the letter and the spirit of the constitution." *McCulloch*, 17 U.S. at 421. I have little doubt that the individual mandate is also "proper." It violates no other provision of the Constitution.[13] *Cf. Comstock*, 130 S. Ct. 13 at 1957 ("[T]he present statute's validity under provisions of the Constitution other than the Necessary and Proper Clause is an issue that is not before us. . . . [Therefore], the relevant inquiry is simply whether the means chosen are reasonably adapted to the attainment of a legitimate end under the commerce power . . . ." (internal quotation marks omitted)). And the mandate is undoubtedly "rationally related" to the end of effectuating the Act's guaranteed issue and community rating reforms. *Id.* at 1956; *Belfast*, 611 F.3d at 804. The

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would result in adverse selection, increased premiums, decreased enrollment, and fleeing insurers—in short, the insurance market would "implode." *See id.* at 13 n.4.

[13] I address the plaintiffs' suggestions that the individual mandate violates the Fifth or Tenth Amendments in Part II.B, *infra*.

mandate arguably renders the insurer regulations practically and economically feasible. Congress found that without the mandate, "many individuals would wait to purchase health insurance until they needed care," 42 U.S.C. § 18091(a)(2)(I)—that is, until they were sick, which would impose enormous costs on insurers and drive them out of the market. And having observed the failed experience of those states that tried to enact insurer reforms without an individual mandate, Congress rationally concluded that one way to prevent this problem was to require that non-exempted individuals enter the insurance risk pool. The Necessary and Proper Clause requires nothing more.

II.

More fundamentally, the plaintiffs have offered two arguments that, they say, undermine the government's position that Congress' commerce power can justify prescribing a rule that compels an individual to buy health insurance. First, they argue that if Congress has the constitutional authority to enact the individual mandate, then there is virtually no limit on its authority, and Art. 1, § 8, cl. 3 of the Constitution (whether standing alone or in concert with the Necessary and Proper Clause) would be transformed into a grant of general police power. Second, they offer, although largely implicitly, that the individual mandate really infringes upon notions of individual liberty and popular sovereignty found either in the Fifth or Tenth Amendments to the Constitution. I take up each argument in turn.

A.

1.

Perhaps at the heart of the plaintiffs' objection to the mandate—adopted by the majority opinion in conclusion, if not in reasoning[14]—is the notion that allowing the individual mandate to stand will convert Congress' commerce power into a plenary federal police power, admitting of no limits and knowing of no bounds. The parade of horribles said to follow ineluctably from upholding the individual mandate includes the federal government's ability to compel us to purchase and consume broccoli, buy General Motors vehicles, and exercise three times a week. However, acknowledging the constitutionality of the individual mandate portends no such impending doom.

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[14] The majority comes perilously close to abandoning the central foundation—the dichotomy between activity and inactivity—on which the plaintiffs and the district court rely for their position that upholding the individual mandate would convert the Commerce Clause into an unlimited general police power. *See* Maj. Op. at 109 ("[W]e are not persuaded that the formalistic dichotomy of activity and inactivity provides a workable or persuasive enough answer in this case."). As I understand the position taken by the plaintiffs and the district court, it is this: if the Commerce Clause affords Congress the power to conscript the unwilling uninsured to enter the stream of commerce and buy insurance, then Congress could also conscript any American to buy any private product at a time and under circumstances not of his own choosing. In other words, the plaintiffs say, the individual mandate extends the Commerce Clause beyond its outer limits precisely because it allows the government to conscript the *inactive* and unwilling. Without drawing the distinction between activity and inactivity, I am at a loss to understand the argument that sustaining the individual mandate would transmute the limited power contained in Art. 1, § 8, cl. 3 of the Constitution into an unlimited general police power. For reasons that remain inexplicable to me, the majority opinion seems to suggest that the individual mandate is a "bridge too far"—in the words of the district court—not because it conscripts the inactive, but rather for some inchoate reason stated at the highest order of abstraction.

At the outset, there is always a danger in evaluating the constitutionality of legislation actually before us solely on the basis of conjecture about what the future may hold. The plaintiffs' heavy reliance on "floodgate fears" and a "parade of dreadfuls calls to mind wise counsel: 'Judges and lawyers live on the slippery slope of analogies; they are not supposed to ski it to the bottom.'" *Buckley v. Am. Constitutional Law Found., Inc.*, 525 U.S. 182, 194 n.16 (1999) (quoting Robert Bork, The Tempting of America: The Political Seduction of the Law 169 (1990)). Federal courts may only be called on to resolve ripe controversies, and it is difficult and hazardous for courts to prejudge the next case or the one after that in a vacuum, devoid of a factually developed record sharpened in the crucible of the adversarial process. *See Baker v. Carr*, 369 U.S. 186, 204 (1962) ("[C]oncrete adverseness . . . sharpens the presentation of issues upon which the court so largely depends for illumination of difficult constitutional questions[.]"). As courts of limited jurisdiction, we ought not lose sight of the legislation before us, viewed in the context of the discrete issues and facts presented. I have little doubt that the federal courts will be fully capable of addressing future problems raised in future cases in the fullness of time.

But a more basic answer is this: upholding the individual mandate leaves fully intact all of the existing limitations drawn around Congress' Commerce Clause power. To begin with, Congress is limited by the constitutional text and Supreme Court doctrine largely to prescribing rules regulating *economic* behavior that has a *substantial* effect on interstate commerce. These powerful limits afford no problem in this case, because Congress has undeniably prescribed a rule (the individual mandate) to regulate economic behavior (consumption of health care services by the uninsured) that has a powerful impact on how, when, and by whom payment is made for health care services. Indeed, the conduct regulated by the Act is even more "quintessentially economic" in nature than the cultivation, possession, and personal use of controlled substances, *see Raich*, 545 U.S. at 25, or the cultivation of wheat for personal consumption, *see Wickard*, 317 U.S. at 119.

In *Lopez* and *Morrison*, the Supreme Court began to flesh out some of the outer limits surrounding Art. I, § 8, cl. 3. Chief Justice Rehnquist, writing for the Court in both instances, posited a series of "significant considerations," none of which pose any problem in this case. *See Morrison*, 529 U.S. at 609-12. First, he observed that the regulated conduct at issue in *Lopez* and *Morrison* was plainly of a noneconomic nature—again, the possession of a handgun within 1000 feet of a school in *Lopez*, and gender-motivated felonious acts of violence in *Morrison*. *See id.* at 610 ("[A] fair reading of *Lopez* shows that the noneconomic, criminal nature of the conduct at issue was central to our decision in that case."). Here, in sharp contrast, Congress has prescribed a rule governing purely economic behavior. As I've noted already, the Act addresses an economic problem of enormous dimension—$43 billion of annual cost shifting from the uninsured to insured individuals and health care providers, 42 U.S.C. § 18091(a)(2)(F)—by prescribing an economic rule governing the timing and method of payment for health care services. In short, the first problem identified in *Lopez* and *Morrison*—that the statutes reached purely intrastate, noneconomic behavior—is not found in this case, and thus the mandate does not, at least for this reason, penetrate beyond the outer limits of Congress' Commerce Clause power.

A second powerful consideration identified by the Court in both *Lopez* and *Morrison* was that the *nexus* between the criminal conduct regulated by the legislation and its impact—even if taken in the aggregate—on interstate commerce was remote and wholly attenuated, and on its own terms provided no limiting principle surrounding the exercise of Congress' commerce power. In both *Lopez* and *Morrison*, the government relied on a lengthy inferential chain of causal reasoning in order to show that the criminal conduct regulated had a substantial effect on interstate commerce. In *Lopez*—where Congress had made no factual findings regarding the effects upon interstate commerce of gun possession in a school zone—the government had to argue, among other things, that the possession of firearms near schools had the natural effect of disrupting the educational process, and that this disruption, over time, would in turn lower the economic productivity of our citizens, causing an adverse effect on the national economy. *See Lopez*, 514 U.S. at 563-64. It's no surprise, then, that the Court found the critical link to interstate commerce wanting, and concluded that if this chain of reasoning were an acceptable means of bridging the gap between the regulated conduct and commerce, precious little would fall outside the ambit of Congress' commerce power. *Id.* at 564. By the same token, in *Morrison*, the Court found wanting Congress' chain of reasoning—that felonious acts of violence against women would, inter alia, cause lost hours in the workplace and drive up hospital costs and insurance premiums, which in turn would have an adverse effect on the national economy. *See Morrison*, 529 U.S. at 615. The problem remained the same as in *Lopez*, even though in *Morrison*, Congress had sought to draw the causal inferences itself through express factual findings. Again, the causal reasoning that was required to link the regulated criminal conduct to interstate commerce was lengthy and attenuated. And again, the very method of reasoning offered by Congress afforded no limitations on its commerce power. *Id.* at 615-16.

In this case, no such complex and attenuated causal story is necessary to locate the regulated conduct's nexus with interstate commerce. Here, the substantial effect on commerce occurs directly and immediately when the uninsured consume health care services in large numbers, do not pay for them in full or maybe even at all, and thereby shift powerful economic costs onto insured individuals and health care providers (as Congress found they do). The nexus between the regulated conduct and interstate commerce could not be more direct. I am at a loss to find even a single "inferential leap[]," Maj. Op. at 146, required to link them. Moreover, Congress unambiguously and in considerable detail drew the connection between the regulated conduct and its substantial effect on interstate commerce through extensive findings of fact. *See* 42 U.S.C. § 18091. Contrary to the majority's claim, here there is no need "to pile inference upon inference," *Lopez*, 514 U.S. at 567, to draw the critical nexus, and, therefore, we face no unlimited exercise of congressional power for that reason.

Moreover, in sharp contrast to *Lopez* and *Morrison*, we are confronted today with a comprehensive economic statute, not a one-off, criminal prohibition. *See Raich*, 545 U.S. at 23-24 (drawing a sharp distinction between "brief, single-subject statute[s]" divorced from a larger regulatory scheme and "lengthy and detailed statute[s] creating a comprehensive framework for regulating" an entire market). The individual mandate is "an essential part of a larger regulation of economic activity," without which "the regulatory scheme would be undercut," *Lopez*, 514 U.S. at 561, and the Supreme Court has endorsed the constitutionality of such comprehensive, economic regulatory schemes, *Raich*, 545 U.S. at 24-25; *see also Hodel v. Indiana*, 452 U.S. 314, 329 n.17 (1981) ("A complex regulatory program such as established by the [Surface Mining] Act can survive a Commerce Clause challenge without a showing that every single facet of the program is independently and directly related to a valid congressional goal. It is enough that the challenged provisions are an integral part of the regulatory program and that the regulatory scheme when considered as a whole satisfies this test."); *Raich*, 545 U.S. at 36 (Scalia, J., concurring in the judgment) ("Though the conduct in *Lopez* was not economic, the Court nevertheless recognized that it could be regulated as 'an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated.'" (quoting *Lopez*, 514 U.S. at 561)). And, according to Eleventh Circuit precedent, "where Congress comprehensively regulates economic activity, it may constitutionally regulate intrastate activity, whether economic or not, so long as the inability to do so would undermine Congress's ability to implement effectively the overlying economic regulatory scheme." *Maxwell II*, 446 F.3d at 1215 (footnote omitted).

The majority, in an effort to distance itself from this precedent, suggests that, because *Raich* involved an as-applied challenge, the inquiry into whether challenged legislation is an "essential part of a larger regulation of economic activity" is only appropriate in as-applied challenges, as opposed to facial ones. Maj. Op. at 158-60. In other words, the majority seems to be saying that, because "the Supreme Court has to date never sustained a statute on the basis of the 'larger regulatory scheme' doctrine in a facial challenge," *id.* at 159, it is irrelevant to the question of the individual mandate's constitutionality that the mandate is an essential part of a larger economic regulatory scheme. There is no doctrinal basis for this view. In *Lopez* itself, the Court applied this principle in the context of a *facial* challenge. In *Raich*, the Court plainly recognized that, unlike the challenge it faced, the challenges to the constitutionality of the Gun-Free School Zones Act in *Lopez*, and, for that matter, to Title III of the Violence Against Women Act in *Morrison*, were facial challenges. Justice Stevens, writing for the majority in *Raich*, said: "Here, respondents ask us to excise individual applications of a concededly valid statutory scheme. In contrast, in both *Lopez* and *Morrison*, the parties asserted that a particular statute or provision fell outside Congress' commerce power in its *entirety*," the very definition of a facial challenge. *Raich*, 545 U.S. at 23 (emphasis added). Indeed, Justice Thomas, dissenting, likewise expressly recognized that "[i]n *Lopez* and *Morrison*, the parties asserted facial challenges." *Id.* at 71 (Thomas, J., dissenting). And of course in *Lopez*, the Court, for the first time, *applied* this very doctrine, explaining that *even though* the Gun-Free School Zones Act targeted purely local, noneconomic behavior, the Court could have upheld it nonetheless if it had been an "essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated." *Lopez*, 514 U.S. at 561. Moreover, a panel of this Court has recently explained in binding precedent that "what distinguished *Raich* from *Morrison* and *Lopez* . . . was the comprehensiveness of the economic component of the regulation," *Maxwell II*, 446 F.3d at 1214—not whether the challenge was facial or as-applied.

Furthermore, the majority's view that the individual mandate is not an essential part of the Act's concededly economic regulatory scheme, *see* Maj. Op. at 162-66, cannot be squared with the economic realities of the health insurance business or the legislative realities of the Act. Nor can this view be squared with the contrary judgment reached by Congress on this very point. Thus, for example, the majority appears to simply cast aside Congress' finding that the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(a)(2)(I). In *Maxwell II*, we explained that "courts have only a limited role in second-guessing" Congress' judgments about whether leaving a class of conduct outside of federal control would "undercut[] Congress's unquestioned authority to regulate the broader interstate market." 446 F.3d at 1215 (internal quotation marks omitted). Faced with evidence that the insurance industry would collapse if the Act's guaranteed issue and community rating provisions were implemented without the individual mandate, Congress had more than "a rational basis for concluding," *Raich*, 545 U.S. at 19, that the individual mandate was essential to the success of the Act's concededly valid and quintessentially economic insurer reforms.[15] In short, the real and substantial limits on the commerce power set forth by the Supreme Court in *Lopez* and *Morrison* would be left wholly intact if we were to uphold the individual mandate.

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[15] Although the majority seems to take comfort in only striking down the individual mandate, *see* Maj. Op. at 207 n.145, all of the parties have agreed that the individual mandate is so essential to the principal insurer reforms that, at

Because the impact on interstate commerce of the conduct that Congress sought to regulate through the individual mandate is so clear and immediate, this case is readily distinguishable from many of the plaintiffs' suggested hypothetical horribles, which suffer from the inference-piling reasoning condemned in *Lopez* and *Morrison*. Thus, for example, in arguing that Congress could force us to purchase broccoli, the plaintiffs necessarily reason as follows: everyone is a participant in the food market; if people buy more broccoli, they will eat more broccoli; eating more broccoli will, in the long run, improve people's health; this, in turn, will

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least for severability purposes, the guaranteed issue and community rating provisions necessarily rise and fall with the individual mandate, Gov't Reply Br. at 58 ("As plaintiffs note, the federal government acknowledged below [and continues to acknowledge] that the guaranteed-issue and community-rating provisions due to take effect in 2014 . . . cannot be severed from the minimum coverage requirement. The requirement is integral to those sections that go into effect along with it in 2014 and provide that insurers must extend coverage and set premiums without regard to pre-existing medical conditions . . ."); States Br. at 63 (stating that the individual mandate cannot be severed from "the core, interrelated health insurance reforms"); NFIB Br. at 60-61 (stating that the mandate and the principal insurer provisions "truly are the heart of the Act," and highlighting the government's concession that the mandate and the insurer reforms "must stand or fall together" (internal quotation marks omitted)).

improve overall worker productivity, thus affecting our national economy. Such reasoning violates the cautionary note that "under the Government's 'national productivity' reasoning, Congress could regulate any activity that it found was related to the economic productivity of individual citizens .... Thus, if we were to accept the Government's arguments, we are hard pressed to posit any activity by an individual that Congress is without power to regulate." *Lopez*, 514 U.S. at 564. By contrast, the economic problem that Congress sought to address through the individual mandate does not depend on any remote or long-term effects on economic productivity stemming from individuals' health care choices; indeed, the mandate does not compel individuals to seek health care at all, much less any particular form of it. Instead, Congress rationally found that the uninsured's inevitable, substantial, and often uncompensated consumption of health care services—of any form—*in and of itself* substantially affects the national economy.

2.

Moreover, this case does not open the floodgates to an unbounded Commerce Clause power because the particular factual circumstances are truly unique, and not susceptible to replication elsewhere. This factual uniqueness would render any holding in this case limited. I add the unremarkable observation that the holding of every case is bounded by the peculiar fact pattern arising therein. *See Licciardello v. Lovelady*, 544 F.3d 1280, 1288 n.8 (11th Cir. 2008) ("Our holding, as always, is limited to the facts before us."); *see also United States v. Hunter*, 172 F.3d 1307, 1310 (11th Cir. 1999)

(Carnes, J., concurring) ("The holdings of a prior decision can reach only as far as the facts and circumstances presented to the Court in the case which produced that decision.").

The health care services market is characterized by five relevant factors, which, when taken in concert, uniquely converge to create a truly *sui generis* problem: (1) the unavoidable need that virtually all of us have to consume medical care; (2) the unpredictability of that need; (3) the high costs associated with the consumption of health care services; (4) the inability of providers to refuse to provide care in emergency situations; and, largely as a result of the previous four factors, (5) the very significant cost shifting that underlies the way medical care is paid for in this country. Gov't Econ. Br. at 1.

These are not just five fortuitous descriptors of the health care market, elevated to artificial constitutional significance. Over the last 75 years the Supreme Court has emphatically and repeatedly counseled a pragmatic approach to Commerce Clause analysis, grounded in a "practical" conception of commercial regulation, "drawn from the course of business." *Swift & Co.*, 196 U.S. at 398; *accord Raich*, 545 U.S. at 25 n.35; *Lopez*, 514 U.S. at 571, 574 (Kennedy, J., concurring); *Wickard*, 317 U.S. at 123-24; *Jones & Laughlin Steel*, 301 U.S. at 41-42. Legislation enacted pursuant to Congress' Commerce Clause power cannot be evaluated in a vacuum, but only in light of the peculiar problems Congress sought to address, what Congress chose to regulate, how Congress chose to regulate, and the connection between the regulated conduct and the problem Congress sought to resolve. Courts must always engage in the "hard work" of "identify[ing] objective markers for confining the analysis in Commerce Clause cases." *Raich*, 545 U.S. at 47 (O'Connor, J., dissenting). Far from being "*ad hoc*" and "illusory," Maj. Op. at 168, these factual criteria are relevant descriptors, drawn from the course of business, of the economic realities Congress confronted. They are, therefore, precisely what the Court has instructed us to consider in the Commerce Clause analysis. And given these unique characteristics of the health care market and the peculiar way these characteristics converge, the individual mandate was part of a practical solution to the cost-shifting problem Congress sought to address.

The first and most basic of these factors is that no individual can opt out of the health care services market, and thus virtually everyone will consume health care services. Individual participation in the health care services market is properly, therefore, a question of *when* and *how* individuals will consume and pay for such services, not *whether* they will consume them. The plaintiffs are correct that there are other markets that, if defined broadly enough, no one may opt out of, such as the markets for food, transportation, and shelter. But the hypothetical mandates—that Congress can force individuals to buy broccoli, GM cars, or homes—do not follow. Neither those markets nor their hypothetical mandates resemble the market and mandate here.

In the first place, unlike the needs for food, transportation, and shelter—which are always present and have largely predictable costs—illness and injury are wholly unpredictable. Individuals who never intend to consume health care, unlike those who never intend to purchase GM cars or broccoli or a home, will nonetheless do so because of accidents, illnesses, and all the vagaries to which one's health is subject. Indeed, the economists concluded that even the most sophisticated methods of predicting medical spending can explain only 25-35% of the variation in the costs incurred by different individuals; "the vast bulk of [medical] spending needs cannot be forecast in advance." Gov't Econ. Br. at 10-11.

In addition, while the costs associated with obtaining food, transportation, and shelter are susceptible to budgeting, this is not the case for health care, which can be so expensive that most everyone must have some access to funds beyond their own resources in order to afford them. *Id.* at 11-12 (explaining that unpredicted medical costs can eclipse the financial assets of "all but the very well-to-do"); *see also* Gov't Reply Br. at 15 ("The 'frequency, timing and magnitude' of a given individual's demand for health care are unknowable." (quoting Jennifer Prah Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. Med. 53, 54-55 (2007))). Moreover, there are lower cost alternatives to purchasing a house or a car, such as renting an apartment, leasing an automobile, or relying on public transportation. There are no realistic alternatives or less expensive substitutes for treating cancer, a heart attack, or a stroke, or for performing a needed organ transplant or hip replacement. Even routine medical procedures, such as MRIs, CT scans, colonoscopies, mammograms, and childbirth, cost more than many Americans can afford. Gov't Econ. Br. at 11. This is not to say that individuals may not budget and plan as best they can for their health care costs, as many surely do, but the combination of uncertain timing, unpredictable malady, and potentially astronomical cost can nonetheless leave individuals wholly unable to pay for the health care services they consume. Indeed, Congress found that "62 percent of all personal bankruptcies are caused in part by medical expenses." 42 U.S.C. § 18091(a)(2)(G).

Largely because of these first three factors—that health care costs are inevitable, unpredictable, and often staggeringly high—the health care services market, unlike other markets, is paid for predominantly through the mechanism of insurance.[16] Gov't Br. at 9 (citing CMS data that payments by private and government insurers comprise 75% of national health care spending). Insurance is thus already intimately linked to the health care services market. People do not similarly insure against the risk that they will need food or shelter, because these needs are apparent and predictable, and people can reliably budget for them. Although the purchase of a car or a home may often be too expensive for many individuals to afford out of pocket, it would be fanciful indeed to suggest that individuals would insure against the sudden and unpredictable purchase of a home or automobile. The plaintiffs admit that "[r]egulations are 'plainly adapted' if they invoke 'the ordinary means of execution.'" NFIB Br. at 42 (quoting *McCulloch*, 17 U.S. at 409, 421). Insurance is the "ordinary means" of paying for health care services. Thus, a mandate to purchase insurance is more appropriately suited to address the problems of non-payment and cost shifting in the health care services market than it would be to address problems in other markets that do not similarly rely on insurance as the primary method of payment.

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[16] The unpredictability and wide variation in health care costs demonstrate why the majority's comparison of average health care costs to the average insurance premium misses the point. Maj. Op. at 140. Individuals pay $4500 in insurance premiums not to avoid the $2000 *average* annual medical bill, but to avoid the *extreme* medical bill. Indeed, the whole point of insurance is to make spending more regular and predictable. Comparing the "average" medical bill with the "average" insurance premium is hollow—insurance is purchased for the very reason that one cannot count on receiving the "average" medical bill every year.

The fourth important factor distinguishing the health care market from all other markets—and peculiarly contributing to the cost shifting that Congress sought to address through the mandate—is the fact that individuals may consume health care services without regard to their ability to pay and often without ever paying for them. Unlike any other sellers in any other marketplace, nearly all hospitals are required by law to provide emergency services to anyone, regardless of ability to pay. *See* EMTALA, 42 U.S.C. § 1395dd. If an individual shows up at the emergency room doorstep with a broken neck from an automobile accident or bleeding from a gunshot wound, or if an individual suffers a heart attack or a stroke, hospitals will not turn him away. Even aside from the federal obligation imposed by EMTALA, by my count, at least ten of the plaintiff states have statutes on the books requiring hospitals with emergency rooms to provide emergency treatment to those in need of it, regardless of ability to pay.[17] Still other plaintiff states have state court judicial rulings imposing similar requirements.[18] And even absent any *legal* duty, many hospitals provide free or deeply discounted care as part of their charitable mission, even when the patient's need does not rise to the level of an emergency. *See Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990)

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[17] *See* Fla. Stat. Ann. § 395.1041(1); Idaho Code Ann. § 39-1391b; La. Rev. Stat. Ann. § 40:2113.4(A); Nev. Rev. Stat. Ann. § 439B.410(1); 35 Pa. Stat. Ann. § 449.8(a); S.C. Code Ann. § 44-7-260(E); Tex. Health & Safety Code Ann. § 311.022(a); Utah Code Ann. § 26-8a-501(1); Wash. Rev. Code § 70.170.060(2); Wis. Stat. Ann. § 256.30(2); *see also* Gov't Br. at 35 (citing testimony before Congress in 1986 that at least 22 states had enacted statutes or issued regulations requiring provision of emergency medical services regardless of ability to pay, and observing that state court rulings impose a common law duty on doctors and hospitals to provide emergency care).

[18] *See, e.g., Thompson v. Sun City Cmty. Hosp., Inc.*, 688 P.2d 605, 610 (Ariz. 1984) ("[A]s a matter of public policy, licensed hospitals in this state are required to accept and render emergency care to all patients who present themselves in need of such care. . . . This standard of care has, in effect, been set by statute and regulation embodying a public policy which requires private hospitals to provide emergency care that is 'medically indicated' without consideration of the economic circumstances of the patient in need of such care."); *Walling v. Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990) ("[L]iability on the part of a private hospital may be based upon the refusal of service to a patient in a case of unmistakable medical emergency.").

(observing in the application of EMTALA that "American hospitals have a long tradition of giving emergency medical aid to anyone in need who appeared on the emergency room doorstep"). One expert from the Heritage Foundation persuasively illustrated this distinction between health care and other markets when recommending in 1989 that the government impose a mandate "to obtain adequate [health] insurance":

> If a young man wrecks his Porsche and has not had the foresight to obtain insurance, we may commiserate but society feels no obligation to repair his car. But health care is different. If a man is struck down by a heart attack in the street, Americans will care for him whether or not he has insurance. If we find that he has spent his money on other things rather than insurance, we may be angry but we will not deny him services—even if that means more prudent citizens end up paying the tab.

Stuart M. Butler, Heritage Found., The Heritage Lectures 218: Assuring Affordable Health Care for All Americans 6 (1989);[19] *see also* Gov't Br. at 37.

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[19] The Heritage Foundation has filed an amicus brief in support of the plaintiffs making clear that this excerpt does not reflect the policy of the Heritage Foundation or even the current beliefs of the speaker; both strongly dispute the efficacy and the constitutionality of the individual mandate. Brief for Heritage Found. as Amicus Curiae Supporting the Plaintiffs at 5-6. I do not doubt the sincerity of this position, and use this statement not to imply that the Heritage Foundation has blessed the individual mandate but rather only for the statement's own value as a persuasively articulated description

This obligation of health care providers to provide free medical care creates market imperfections that fall under a variety of labels: "an externality (a situation where one person's actions or inactions affect[] others), a free-rider problem (where people buy [or consume] a good and leave the costs to others), or a Samaritan's dilemma (where people choose not to be prepared for emergencies, knowing that others will care for them if needed)." Gov't Econ. Br. at 14-15. Individuals who decline to purchase health insurance are not held to the full economic consequence of that choice, as society does not refuse medical care to a patient in need, even when its cost far exceeds the individual's ability to pay. The ability of health care market participants to demand services without paying for them bolsters Congress' rational conclusion that the individual mandate—which helps to assure payment for services in advance—is peculiarly suited to addressing a unique economic problem in the health care market.[20]

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of an important distinction between health insurance, health care, and other markets.

[20] Contrary to the plaintiffs' suggestion, it is not problematic that Congress' own legislation—EMTALA—may have contributed to the very market conditions that it sought to address in the Act. Significantly, EMTALA predated the individual mandate by over two decades, and was enacted for reasons wholly unrelated to the mandate. Moreover, EMTALA did not create a new federal obligation out of whole cloth and then impose it on health care providers; rather, it supplemented numerous state laws and overarching social judgments that the sick and injured should be cared for regardless of ability to pay. Nor should we be concerned that Congress might similarly enact legislation requiring companies

Finally, the four factors described above converge to cause a fifth unique factor of the health care market: the substantial cost shifting from the uninsured to current participants in the health insurance market and to health care providers. This cost shifting does not occur in other markets, even those in which we all participate, such as transportation, food, or housing. When an individual purchases a home or a car, the purchaser pays all of the cost (whether upfront or over time through a loan or mortgage). My neighbor will not help cover my costs of purchasing a home by paying a higher price for his own house. And I will not pay more for my car, simply because my neighbor cannot afford to buy one for himself. The costs in those markets are borne by the individual purchaser alone. Again, in sharp contrast, the uninsured shift substantial costs to the insured and to health care providers, because the uninsured in the aggregate consume health care services in large numbers and yet bear only a small fraction of the costs for the services they consume. The parties agree that the uninsured fail to pay for 63% of the health care services they receive, and

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to give away cars, food, or housing, and then accompany that legislation with a mandate prescribing the pre-purchase of a mechanism for financing those items. Not only is it wholly unrealistic that Congress would require companies to give away free cars or housing (even if it could do so) simply so that it could then impose an insurance requirement on those items, but cars and houses are also products not already predominantly financed through insurance. An insurance mandate thus would not be a well-suited means to regulate payment in those markets.

some 37% (amounting to $43 billion) of all health care costs incurred by the uninsured are uncompensated entirely. States Br. at 30-31; Gov't Reply Br. at 8-9, 11. Congress found that this uncompensated care increases the average insured family's annual insurance premiums by $1000. 42 U.S.C. § 18091(a)(2)(F). This cost-shifting phenomenon simply does not occur in other industries.[21] Even under the majority's characterization of the regulated conduct as a "decision not to purchase health insurance," Maj. Op. at 164, deciding to self-insure in the health care market, unlike all other "financial decisions of Americans," *id.* at 115, is a decision to pay for your care if you can afford it *or* to shift costs onto society if you can't.

In sum, the particular problems riddling the health care industry that Congress sought to address, together with the unique factors that characterize the health care market and its peculiar interconnectedness with the health insurance market, all led Congress to enact the individual mandate as an appropriate means of ameliorating two large national problems. Although these economic factors "are not precise formulations, and in the nature of things they cannot be[,] . . . [I] think they point the way to a correct decision of this case." *Lopez*, 514 U.S. at 567; *see also id.* at 579 (Kennedy, J., concurring) ("[A]s the branch whose distinctive duty it is to declare 'what the law is,' we are often called upon to resolve questions of constitutional law not susceptible to the mechanical application of bright and clear lines." (citation omitted) (quoting *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803))).

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[21] Perhaps the closest analog to the individual mandate is a requirement that individuals buy other types of insurance. The district court rejected the government's contention that the failure to buy health insurance is a "financing decision" by reasoning that "this is essentially true of any and all forms of insurance." *Florida*, 2011 WL 285683, at *28; *see also* Maj. Op. at 133. But of the examples suggested by the district court—supplemental income, credit, mortgage guaranty, business interruption, or disability insurance—none insures against risks or costs that are inevitable, or that will otherwise be subsidized by those with insurance, unlike the relationship between health insurance and health care services.

Upholding the mandate under the particular circumstances of this case would do little to pave the way for future congressional mandates that address wholly distinct problems that may arise in powerfully different contexts. While the individual mandate is indeed novel, I cannot accept the charge that it is a "bridge too far." The individual mandate, viewed in light of the larger economic regulatory scheme of the Act as a whole and the truly unique and interrelated nature of both markets, is a legitimate exercise of Congress' power under Art. I, § 8, cl. 3 of the Constitution and is not prone to the slippery slope of hypothetical horrors leading to an unlimited federal Commerce Clause power.

B.

Finally, implicit in the plaintiffs' Commerce Clause challenge, and providing the subtext to much of the majority's opinion, is the deeply rooted fear that the federal government is infringing upon the individual's right to be left alone—a fear that is intertwined with a visceral aversion to the government's making us do something we do not want to do (in this case, buy a product we do not wish to purchase). The plaintiffs say that Congress cannot compel unwilling individuals to engage in a private commercial transaction or otherwise pay a penalty. The difficulty, however, is in finding firm constitutional footing for the objection. The plaintiffs suggest that the claim derives, if anywhere, from either of two constitutional provisions: the Fifth Amendment's Due Process Clause or the Tenth Amendment. If derived from the Fifth Amendment, the objection, fairly stated, is that the mandate violates individual liberty, as protected by the substantive component of the Due Process Clause. In the alternative, if derived from the Tenth Amendment, the objection is that the individual mandate infringes on the powers, or rights, retained by "the people."

At the trial court, the plaintiffs squarely raised a Fifth Amendment substantive due process challenge to the individual mandate, which the district court flatly rejected. *Florida ex rel. McCollum v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1161-62 (N.D. Fla. 2010). And while the plaintiffs also challenged the individual mandate on Tenth Amendment grounds, the district court addressed this challenge only implicitly in ruling that the mandate exceeded Congress' commerce power. *Florida*, 2011 WL 285683, at *33.

On appeal, the plaintiffs have expressly disclaimed any substantive due process challenge to the individual mandate, although they appear still to advance a Tenth Amendment challenge. Nevertheless, it is clear that individual liberty concerns lurk just beneath the surface, inflecting the plaintiffs' argument throughout, although largely dressed up in Commerce Clause and Necessary and Proper Clause terms. For example, the state plaintiffs go so far as to say that the individual mandate is "one of the Act's principal threats to individual liberty," States Br. at 16, and that upholding it would "sound the death knell for our constitutional structure and individual liberties," *id.* at 19. Similarly, the private plaintiffs claim that the individual mandate "exemplifies the threat to individual liberty when Congress exceeds its enumerated powers and attempts to wield a plenary police power." NFIB Br. at 7. Sounding almost entirely in economic substantive due process, the private plaintiffs also assert that "[a]mong the most longstanding and fundamental rights of Americans is their freedom from being forced to give their property to, or contract with, other private parties." *Id.* at 47. Thus, to the extent the plaintiffs' individual liberty-based challenge to the individual mandate derives from the Fifth and Tenth Amendments, I address each constitutional source in turn.

The Fifth Amendment provides that "[n]o person shall . . . be deprived of life, liberty, or property, without due process of law." U.S. CONST. amend. V. Although the Due Process Clause has both a procedural and a substantive component, only its substantive aspect is implicated here. "The substantive component [of the Due Process Clause] protects fundamental rights that are so implicit in the concept of ordered liberty that neither liberty nor justice would exist if they were sacrificed." *Doe v. Moore*, 410 F.3d 1337, 1342 (11th Cir. 2005) (internal quotation marks omitted). This narrow band of fundamental rights is largely protected from governmental action, regardless of the procedures employed. *Id.* at 1343. And any law, whether federal *or* state, that infringes upon these rights will undergo strict scrutiny review, which means that the law must be "narrowly tailored to serve a compelling state interest." *Id.* (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)). Today, substantive due process protects only a small class of fundamental rights, including "the rights to marry, to have children, to direct the education and upbringing of one's children, to marital privacy, to use contraception, to bodily integrity, and to abortion," *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) (citations omitted)—a list the Supreme Court has been "very reluctant to expand," *Moore*, 410 F.3d at 1343.

In a bygone period known as "the *Lochner* era,"[22] however, substantive due process was more broadly interpreted as also encompassing and protecting the right, liberty, or freedom of contract. *See, e.g.*, *Adkins v. Children's Hosp. of D.C.*, 261 U.S. 525, 545 (1923); *Adair v. United States*, 208 U.S. 161, 174-75 (1908). Through this interpretation of the Due

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[22] The name refers, of course, to *Lochner v. New York*, 198 U.S. 45 (1905), where the Supreme Court struck down a New York law setting maximum hours for bakery employees on the ground that it violated the right of contract, as protected by the Fourteenth Amendment's Due Process Clause.

Process Clause, the Supreme Court struck down many federal and state laws that sought to regulate business and industrial conditions. *See, e.g.*, *Adkins*, 261 U.S. 525 (striking down a federal law fixing minimum wages for women and children in the District of Columbia); *Jay Burns Baking Co. v. Bryan*, 264 U.S. 504 (1924) (striking down a Nebraska law regulating the weight of loaves of bread for sale).

However, the Supreme Court has long since abandoned the sweeping protection of economic rights through substantive due process. *See, e.g.*, *Ferguson v. Skrupa*, 372 U.S. 726, 730 (1963) ("The doctrine that prevailed in *Lochner* . . . and like cases—that due process authorizes courts to hold laws unconstitutional when they believe the legislature has acted unwisely—has long since been discarded."); *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 488 (1955) ("The day is gone when this Court uses the Due Process Clause of the Fourteenth Amendment to strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a particular school of thought."); *West Coast Hotel Co. v. Parrish*, 300 U.S. 379, 391 (1937). Today, economic regulations are presumed constitutional, *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976), and are subject only to rational basis review, *Vesta Fire Ins. Corp. v. Florida*, 141 F.3d 1427, 1430 n.5 (11th Cir. 1998).

In substantive due process cases, binding precedent requires that we "carefully formulat[e]" the alleged fundamental right, *Glucksberg*, 521 U.S. at 722, which must be "defined in reference to the scope of the [statute at issue]," *Williams v. Att'y Gen. of Ala.*, 378 F.3d 1232, 1241 (11th Cir. 2004). In light of the individual mandate's scope, the carefully formulated right would be the right of non-exempted individuals to refuse to maintain a minimum level of health insurance. And this right—whether cast as the freedom to contract, the right to remain uninsured, or, in the words of one commentator, the "right to force a society to pay for your medical care by taking a free ride on the system"[23]—cannot be characterized as a "fundamental" one receiving heightened protection under the Due Process Clause. The present state of our jurisprudence does not recognize any such right as a "fundamental" one, "deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if [it] were sacrificed." *Williams*, 378 F.3d at 1239 (quoting *Glucksberg*, 521 U.S. at 720-21).

Since the individual liberty interest asserted by the plaintiffs is not a fundamental right, we are obliged to apply rational basis review, which only asks whether the mandate is rationally related to a legitimate government interest. *TRM, Inc. v. United States*, 52 F.3d 941, 945 (11th Cir. 1995). Under rational basis review, "legislation must be sustained if there is any conceivable basis for the legislature to believe that the means they have selected will tend to accomplish the desired end." *Id.* at 945-46 (internal quotation marks omitted); *see also Williams v. Morgan*, 478 F.3d 1316, 1320 (11th Cir. 2007) ("A statute is constitutional under rational basis scrutiny so long as '*there is any reasonably conceivable state of facts* that could provide a rational basis for the [statute].'" (alteration in original) (quoting *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313 (1993))).

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[23] *See* Is the Obama Health Care Reform Constitutional? Fried, Tribe and Barnett Debate the Affordable Care Act, Harvard Law School (Mar. 28, 2011), http://www.law.harvard.edu/news/spotlight/constitutional-law/is-obama-health-care-reform-constitutional.html.

Here, Congress rationally found that the individual mandate would address the powerful economic problems associated with cost shifting from the uninsured to the insured and to health care providers, and with the inability of millions of uninsured individuals to obtain health insurance. Thus, to the extent the plaintiffs' individual liberty concerns are rooted in the Fifth Amendment's Due Process Clause, they must fail.

The plaintiffs' more provocative argument is found in the Tenth Amendment, which provides that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. CONST. amend. X. The plaintiffs do not explicitly flesh out *how* the mandate violates the Tenth Amendment. The state plaintiffs cite the Tenth Amendment generally, claiming that "[i]f this Court were to uphold [the individual mandate and the Act's Medicaid expansion], there would remain little if any power 'reserved to the States . . . or to the people.'" States Br. at 3 (alteration in original) (quoting U.S. CONST. amend. X).[24] And the private plaintiffs suggest that the portion of the amendment reserving undelegated power to the *people* provides the basis for their individual liberty claim. *See* NFIB Br. at 46 (reciting "the Tenth Amendment's admonition that the non-enumerated powers 'are reserved to the States respectively, *or to the people*.'" (quoting U.S. CONST. amend. X) (emphasis in original)); *see also* Brief for Cato Institute as Amicus Curiae Supporting the Plaintiffs at 24 ("[T]he text of the Tenth Amendment protects not just state sovereignty, but also popular sovereignty.").

The Supreme Court, however, has said precious little about the tail end of the Tenth Amendment that reserves power to the people. Indeed, no case, either from the Supreme Court or from any lower federal court, has ever invoked this portion of the amendment to strike down an act of Congress. Instead, the Supreme Court's Tenth Amendment cases have grappled almost exclusively with the balance of power between the federal government and the *states*.[25]

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[24] Indeed, when asked at oral argument if the Tenth Amendment had been abandoned on appeal, counsel for the states reiterated that "the Tenth Amendment is still very much in this case," and that "this is both an individual rights case and a Commerce Clause enumerated rights case."

[25] In *Bond v. United States*, __ U.S. __, 131 S. Ct. 2355 (2011), the Supreme Court recently held that an individual has prudential standing to "assert injury from governmental action taken in excess of the authority that federalism defines." *Id.* at 2363-64. In other words, Carol Anne Bond had standing to

In these cases, the Supreme Court has interpreted the Tenth Amendment's reservation of power to the states to mean that the federal government may not "commandeer[] the legislative processes of the States by directly compelling them to enact and enforce a federal regulatory program." *New York*, 505 U.S. at 176 (quoting *Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 288 (1981)); *see* also *Printz v. United States*, 521 U.S. 898, 935 (1997) ("The Federal Government may neither issue directives requiring the States to address particular problems, nor command the States' officers, or those of their political subdivisions, to administer or enforce a federal regulatory program."). The Court has thus held that federal laws compelling state governments to enact legislation providing for the disposal of radioactive waste, *New York*, 505 U.S. at 149, and compelling state agents to conduct background checks on prospective handgun purchasers, *Printz*, 521 U.S. at 902, violate the Tenth Amendment. In so holding, the Supreme Court has explained that the limits the Tenth Amendment imposes on Congress' power come not from the amendment's text, but rather from the principle of federalism, or dual sovereignty, that the

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raise federalism-based arguments in challenging the constitutionality of the criminal statute under which she was indicted, 18 U.S.C. § 229 (which prohibits the knowing development, acquisition, possession, or use of chemical weapons). *Id.* at 2360. It remains true, however, that the Court has never used the "people" prong of the Tenth Amendment to invalidate an act of Congress.

Tenth Amendment embodies. *See New York*, 505 U.S. at 156-57.

But because of the utter lack of Supreme Court (or any other court) precedent, the amendment's "people" prong provides little, if any, support here. It may be that in time the law will come to breathe practical life into the Tenth Amendment's reservation of power to the people, but that day has not yet arrived.

Setting aside the lack of *any* precedent on point, a Tenth Amendment challenge to the individual mandate fails for an additional, and critical, reason: when a federal law is properly within Congress' delegated power to enact, the Tenth Amendment poses no limit on the exercise of that power. *See, e.g.*, *New York*, 505 U.S. at 156 ("If a power is delegated to Congress in the Constitution, the Tenth Amendment expressly disclaims any reservation of that power to the States . . . ."); *Midrash Sephardi, Inc. v. Town of Surfside*, 366 F.3d 1214, 1242 (11th Cir. 2004) ("Because [the Religious Land Use and Institutionalized Persons Act] is a proper exercise of Congress's power under § 5 of the Fourteenth Amendment, there is no violation of the Tenth Amendment."); *United States v. Williams*, 121 F.3d 615, 620 (11th Cir. 1997) ("[T]he [Child Support Recovery Act] is a valid exercise of Congress's power under the Commerce Clause, and Congress's 'valid exercise of authority delegated to it under the Constitution does not violate the Tenth Amendment.'" (quoting *Cheffer v. Reno*, 55 F.3d 1517, 1519 (11th Cir. 1995))); *N. Ala. Express, Inc. v. ICC*, 971 F.2d 661, 666 (11th Cir. 1992) ("Because the Tenth Amendment reserves only those powers not already delegated to the federal government, the Tenth Amendment has been violated only if [the federal law at issue] goes beyond the limits of Congress' power under the Commerce Clause."). Since the individual mandate falls within Congress' commerce power, its enactment is a proper exercise of a power "delegated to the United States by the Constitution." U.S. CONST. amend. X. The Tenth Amendment, therefore, has no independent role to play. In short, the plaintiffs' individual liberty claims find little support in the Constitution—whether pegged to the Fifth Amendment's Due Process Clause or to the Tenth Amendment's reservation of power to the people.

At bottom, Congress rationally concluded that the uninsured's consumption of health care services, in the aggregate, shifts enormous costs onto others and thus substantially affects interstate commerce. The individual mandate directly and unambiguously addresses this cost-shifting problem by regulating the timing and means of payment for the consumption of these services. Congress also fairly determined that the mandate is an essential part of the Act's comprehensive regulation of the health insurance market. I would, therefore, uphold the mandate as constitutional, and I respectfully dissent on this critical point.

APPENDIX A: OVERALL STRUCTURE OF ACT'S NINE TITLES

The Act's nine Titles are:

I. Quality, Affordable Health Care for All Americans

II. Role of Public Programs

III. Improving the Quality and Efficiency of Health Care

IV. Prevention of Chronic Disease and Improving Public Health

V. Health Care Workforce

VI. Transparency and Program Integrity

VII. Improving Access to Innovative Medical Therapies

VIII. Community Living Assistance Services and Supports

IX. Revenue Provisions[1]

We outline here the structure and many of the key provisions in these nine Titles.

Title I reforms the business and underwriting practices of insurance companies and overhauls their health insurance products. Title I requires that private insurers change their practices and products and offer new and better health insurance policies for consumers. Title I's hefty insurance reforms include: (1) elimination of preexisting conditions exclusions for children immediately, Act §§ 1201, 1255 (as re-numbered by §§ 10103(f)), 10103(e));[2] (2) elimination of preexisting conditions for adults in 2014, §§ 1201, 1255 (as re-numbered by § 10103(f)); (3) elimination of annual and lifetime limits on benefits, §§ 1001, 10101(a); (4) required coverage for preventive services, § 1001; (5) immediate extension of dependent coverage up to age 26, § 1001; (6) imposition of a cap on insurers' administrative costs in relation to their claims-payments (the medical loss ratio), §§ 1001, 10101(f); (7) prohibition on excessive waiting periods to obtain coverage, §§ 1251, 10103(b); (8) guaranteed issue of coverage and guaranteed renewability in 2014, §§ 1201, 1255 (as re-numbered by § 10103(f)(1)); (9) prohibition on rescission except on limited grounds, § 1001; (10) prohibition of coverage denial based on health status, medical condition, claims experience, genetic information, or other health-related factors, § 1201; (11) "community-rated" premiums, § 1201; (12) prohibition of discrimination based on salary, §§ 1001, 10101(d); (13) development and utilization of uniform explanation of coverage documents and standardized definitions, § 1001; (14) coverage appeals process, §§ 1001, 10101(g); and (15) insurance offerings for persons who retire before age 65, § 1102.

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[1] There is also a tenth Title dedicated to amendments to these nine Titles. Although the amendments are actually located in Title X, we list the substance of the amendments under the Title being amended.

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[2] In this Appendix, we provide citations to the sections of the Act. Our opinion's in-depth discussion of the contents of specific provisions, however, cites to the sections of the U.S. Code where each provision is now, or will be, codified.

In addition to requiring insurers to offer new, improved health insurance products, Title I creates new state-run marketplaces for consumers to buy those new products, accompanied by federal tax credits and subsidies. Title I establishes state-administered Health Benefit Exchanges where both individuals and small groups can, and are encouraged to, purchase health insurance plans through non-profits and private insurers. §§ 1301–1421, 10104–10105. The Exchanges allow individuals, families, and small businesses to pool resources together and obtain premium prices competitive with those of large employer group plans. § 1311. The Exchange provisions include: (1) state flexibility to establish basic health programs for low-income individuals not eligible for Medicaid, § 1331; (2) transitional reinsurance program for sellers of insurance in the individual and small group markets in each state, § 1341; (3) establishment of a temporary risk corridor program for plans in individual and small group markets, § 1342; (4) refundable premium-assistance tax credit and reduced cost-sharing for individuals enrolled in qualified health plans, §§ 1401–02; (5) tax credits for small businesses' employee health insurance expenses, § 1421; and (6) streamlining of enrollment procedures through the Exchanges, Medicaid, CHIP, and health subsidy programs, § 1413.

Title I next addresses employers. Title I imposes penalties on certain employers if they do not offer any, or an adequate, health insurance plan to their employees. § 1513. Title I contains provisions regarding "automatic enrollment" for employees of large corporations, reporting requirements, informing employees of coverage options, and offering of Exchange-participating health plans through "cafeteria" plans. §§ 1511–1515. Miscellaneous Title I provisions include transparency in government, equity for certain eligible survivors, health information technology enrollment standards and protocols, and prohibition against discrimination on refusal to furnish services or goods used to facilitate assisted suicide. §§ 1552, 1553, 1556, 1561.

Title I contains the individual mandate, which requires individual taxpayers either to purchase health insurance or pay a monetary penalty with their federal tax return. § 1501. Title I includes three exemptions from the mandate and five exceptions to the penalty, which together exclude many uninsured persons from the individual mandate. § 1501.

Title II shifts the Act's focus to publicly-funded programs such as Medicaid, CHIP, and initiatives under the Indian Health Care Improvement Act. As to Medicaid, Title II's provisions: (1) expand Medicaid eligibility to 133% of the federal poverty level, § 2001; (2) provide Medicaid coverage for former foster children, § 2004; (3) rescind the Medicaid Improvement Fund, § 2007; (4) permit hospitals to make presumptive eligibility determinations for all Medicaid-eligible populations, § 2202; (5) extend Medicaid coverage to freestanding birth center services and concurrent care to children, §§ 2301–02; (6) require premium assistance to Medicaid recipients for employer-sponsored coverage, § 2003; (7) provide a state eligibility option for Medicaid family planning services, § 2303; (8) create a Community First Choice Option for Medicaid, § 2401; (9) remove barriers to providing home- and community-based services through Medicaid, § 2402; (10) reauthorize Medicaid programs aimed at moving beneficiaries out of institutions and into their own homes or other community settings, § 2403; and (11) protect Medicaid recipients of home- and community-based services against spousal impoverishment, § 2404.

As to CHIP, Title II provides enhanced federal support and funding. § 2101. The Act: (1) reauthorizes CHIP through September 2015, § 10203; and (2) from October 2015 through September 2019, increases state matching rates for CHIP by 23 percentage points, up to a 100% cap, § 2101. Title II requires states to maintain CHIP eligibility through September 2019. § 2101.

Title II also amends and extends the Indian Health Care Improvement Act ("IHCIA"). § 10221. The Act's IHCIA amendments, *inter alia*: (1) make the IHCIA's provisions permanent; (2) expand programs to address diseases, such as diabetes, that are prevalent among the Indian population; (3) provide funding and technical assistance for tribal epidemiology centers; (4) establish behavioral health initiatives, especially as to Indian youth suicide prevention; and (5) authorize long-term care and home- and community-based care for the Indian health system. § 10221; *see* S.1790, 111th Cong. (2009).

Title II's provisions also create, or expand, other new publicly-funded programs that: (1) establish a pregnancy assistance fund for pregnant and parenting teens and women, § 10212; (2) fund expansion of State Aging and Disability Resource Centers, § 2405; (3) fund maternal, infant, and early childhood home visiting programs in order to reduce infant and maternal mortality, § 2951; (4) provide for support, education, and research for postpartum depression, § 2952; (5) support personal responsibility education, § 2953; (6) restore funding for abstinence education, § 2954; and (7) require inclusion of information about the importance of foster-care children designating a health care power of attorney for them as part of their transition planning for aging out of either foster care or other programs, § 2955.

Title III primarily addresses Medicare. Title III establishes new Medicare programs, including: (1) a value-based purchasing program for hospitals that links Medicare payments to quality performance on common, high-cost conditions, § 3001; (2) a Center for Medicare & Medicaid Innovation to research and develop innovative payment and delivery arrangements, § 3021; (3) an Independent Payment Advisory Board to present to Congress proposals to reduce Medicare costs and improve quality, §§ 3403, 10320(b); and (4) a new program to develop community health teams supporting medical homes to increase access to community-based, coordinated care, §§ 3502, 10321. Title III revises the Medicare Part D prescription drug program and reduces the so-called "donut hole" coverage gap in that program.[3] § 3301. Title III extends a floor on geographic adjustments to the Medicare fee schedule to increase provider fees in rural areas. § 3102.

Other sundry Medicare provisions in Title III include: (1) quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs, § 3004; (2) permitting physician assistants to order post-hospital extended care services, § 3108; (3) exemption of certain pharmacies from accreditation requirements, § 3109; (4) payment for bone density tests, § 3111; (5) extensions of outpatient hold-harmless provisions, the Rural Community Hospital demonstration project, and the Medicare-dependent hospital program, §§ 3121, 3123–24; (6) payment adjustments for home health care, § 3131; (7) hospice reform, § 3132; (8) revision of payment for power-driven wheelchairs, § 3136; (9) payment for biosimilar biological products, § 3139; (10) an HHS study on urban Medicare-dependent hospitals, § 3142; (11) Medicare Part C benefit protection and simplification amendments, § 3202; and (12) an increase in premium amount for high-income

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[3] The Medicare Part D "donut hole" is the gap in prescription drug coverage, where beneficiaries' prescription drug expenses exceed the initial coverage limit but do not yet reach the catastrophic coverage threshold, meaning beneficiaries must pay 100% of those prescription drug costs. See 42 U.S.C. § 1395w-102(b)(3)(A), (b)(4) (2009). In 2006, the donut hole extended to yearly prescription drug expenses between $2,250 and $3,600, with values for later years adjusted by an annual percentage increase. *See id.*

Medicare Part D beneficiaries, § 3308. Title III also includes new federal grants for (1) improving women's health, § 3509; (2) health care delivery system research, § 3501; and (3) medication management services in treatment of chronic diseases, § 3503.

Title IV concentrates on prevention. Title IV creates the National Prevention, Health Promotion, and Public Health Council, and authorizes $15 billion for a new Prevention and Public Health Fund to support initiatives from smoking cessation to fighting obesity. §§ 4001, 4002. Title IV authorizes new publicly-funded programs for (1) an oral healthcare prevention education campaign, § 4102; (2) Medicare coverage for annual wellness visits, § 4103; and (3) the operation and development of school-based health clinics, § 4101. Title IV also: (1) waives Medicare coinsurance requirements and deductibles for most preventive services, § 4104; and (2) provides states with an enhanced funds-match if the state Medicaid program covers certain clinical preventive services and adult immunizations, § 4106. Title IV further provides for: (1) Medicaid coverage of comprehensive tobacco cessation services for pregnant women, § 4107; (2) community transformation grants, § 4201; (3) nutrition labeling of standard menu items at chain restaurants, § 4205; (4) reasonable break time for nursing mothers and a place, other than a bathroom, which may be used, § 4207; (5) research on optimization of public health services delivery, § 4301; (6) CDC and employer-based wellness programs, § 4303; (7) advancing research and treatment for pain care management, § 4305; (8) epidemiology-laboratory capacity grants,

§ 4304; and (9) funding for childhood obesity demonstration projects, § 4306.

Title V seeks to increase the supply of health care workers through education loans, training grants, and other spending. Title V: (1) modifies the federal student loan program, § 5201; (2) increases the nursing student loan program, § 5202; and (3) establishes a loan repayment program for pediatric subspecialists, juvenile mental health providers, and public health workers who practice in underserved areas, § 5203. Title V also provides for: (1) state health care workforce development grants, § 5102; (2) a national health care workforce commission, § 5101; (3) nurse-managed health clinics, § 5208; (4) workforce diversity grants, § 5404; (5) training in general, pediatric, and public health dentistry, § 5303; (6) mental and behavioral health education and training grants, § 5306; (7) advanced nursing education grants, § 5309; (8) grants to promote the community health workforce, § 5313; (9) spending for Federally Qualified Health Centers, § 5601; and (10) reauthorization of the Wakefield Emergency Medical Services for Children program, § 5603. Title V addresses: (1) the distribution of additional residency positions, § 5503; and (2) rules for counting resident time for didactic and scholarly activities and in non-provider settings, §§ 5504–05.

Title VI creates new transparency and anti-fraud requirements for physician-owned hospitals participating in Medicare and for nursing facilities under Medicare or Medicaid. Title VI authorizes the HHS Secretary to (1) reduce civil monetary penalties for facilities that self-report and correct deficiencies, § 6111; and (2) establish a nationwide background-check program for employees of certain long-term support and service facilities, § 6201. Title VI also provides: (1) screening of providers and suppliers participating in Medicare, Medicaid, and CHIP, § 6401; and (2) new penalties for false statements on applications or contracts to participate in a federal health care program, § 6408.

Title VI also includes the Elder Justice Act, designed to prevent and eliminate elder abuse, neglect, and exploitation. § 6703. Other Title VI provisions include: (1) dementia and abuse prevention training, § 6121; (2) patient-centered outcomes research funded by a $2 fee on accident or health insurance policies, § 6301; (3) federal coordinating counsel for comparative effectiveness research, § 6302; (4) enhanced Medicare and Medicaid program integrity provisions, § 6402; (5) elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank, § 6403; (6) reduction of maximum period for submission of Medicare claims to not more than 12 months, § 6404; (7) requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse, § 6406; (8) requirement of face-to-face encounter before physicians may certify eligibility for home health services or durable medical equipment under Medicare, § 6407; (9) prohibition on Medicaid payments to institutions or entities outside the United States, § 6505; (10) enablement of the Department of Labor to issue administrative summary cease-and-desist orders and summary seizure orders against plans in financially hazardous condition, § 6605; and (11) mandatory state use of the national correct coding initiative, § 6507.

Title VII extends and expands the drug discounts through the 340B program.[4] § 7101. Title VII establishes a process for FDA licensing of biological products shown to be biosimilar or interchangeable with a licensed biological product. § 7002.

Title VIII establishes a national voluntary long-term care insurance program for purchasing community living assistance services and support by persons with functional limitations. § 8002.

Title IX includes: (1) an excise tax on high-premium employer-sponsored health plans, § 9001; (2) an increase in taxes on distributions from individuals' health savings accounts, § 9004; (3) increases in the employee portion of the FICA hospital insurance tax for employees with wages over certain threshold amounts, § 9015; (4) an additional tax of 3.8% on investment income above certain thresholds to fund Medicare, §§ 9001, 10901; HCERA § 1402; (5) a $2,500 limitation on individuals' health flexible spending accounts under cafeteria plans, § 9005; (6) imposition of an annual fee on manufacturers and importers of branded prescription drugs, § 9008; (7) elimination of the tax deduction for expenses allocable to the Medicare Part D subsidy, § 9012; (8) a decrease in the itemized tax deduction for medical expenses, § 9013; and (9) an excise tax on indoor tanning services, § 10907. Title IX also provides for: (1) inclusion of the cost of employer-sponsored health coverage on W-2 forms, § 9002; (2) expansion of information-reporting requirements, § 9006; (3) additional requirements for hospitals to receive "charitable" designation and tax status, § 9007; (4) a study and report on the effect of the Act's new fees on drug manufacturers and insurers on veterans' health care, § 9011; (5) prohibition on health insurers' deducting employee compensation over $500,000, § 9014; (6) tax credit for companies with fewer than 250 employees that are engaged in research on qualifying therapeutic discoveries, § 9023; and (7) establishment of simple cafeteria plans for small businesses, § 9022. Title IX assesses an annual fee on health insurance companies, which is apportioned among insurers based on a ratio designed to reflect each insurer's share of the net premiums written in the United States health care market. §§ 9010, 10905; HCERA § 1406.

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[4] Section 340B of the Public Health Service Act, 42 U.S.C. § 256b, establishes a program whereby HHS enters into contracts with manufacturers of certain outpatient drugs under which the manufacturers provide those drugs at discounted prices to "covered entities"—generally, certain enumerated types of federally funded health care facilities serving low-income patients. *Id.*; *see generally Univ. Med. Ctr. of S. Nev. v. Shalala*, 173 F.3d 438, 439 (D.C. Cir. 1999).

No. _____

In the

Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTAD, GOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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PETITIONERS' APPENDIX — VOLUME II

SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

September 27, 2011 *(Additional Counsel Listed on Inside Cover)*

JOHN W. SUTHERS
Attorney General
of Colorado
1525 Sherman Street,
Denver, CO 80203

THOMAS W. CORBETT, JR.
Governor
LINDA L. KELLY
Attorney General
Commonwealth of
Pennsylvania
16th Floor
Strawberry Square
Harrisburg, PA 17120

MARTY J. JACKLEY
Attorney General
of South Dakota
1302 East Highway 14
Pierre, SD 57501

GREGORY F. ZOELLER
Attorney General of Indiana
302 West Washington Street
Indianapolis, IN 46204

BRIAN SANDOVAL
Governor of Nevada
State Capitol Building
101 North Carson Street
Carson City, NV 89701

ROBERT M. MCKENNA
Attorney General
of Washington
1125 Washington Street S.E.
P.O. Box 40100
Olympia, WA 98504

JOSEPH SCIARROTTA, JR.
General Counsel
Office of Arizona Governor
JANICE K. BREWER
TOM HORNE
Attorney General of Arizona
1700 West Washington
Street, 9th Floor
Phoenix, Arizona 85007

WAYNE STENEJHEM
Attorney General
of North Dakota
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

LAWRENCE G. WASDEN
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720

BILL COBB
Deputy Attorney General
for Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

PAMELA JO BONDI
Attorney General of Florida
PL-01, The Capitol
Tallahassee, FL 32399

JON BRUNING
Attorney General
of Nebraska
P.O. Box 98920
Lincoln, NE 68509

MARK L. SHURTLEFF
Attorney General of Utah
Capitol Suite #230
P.O. Box 142320
Salt Lake City, UT 84114

LUTHER STRANGE
Attorney General
of Alabama
501 Washington Avenue
Montgomery, AL 36130

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508
(402) 471-2834

ALAN WILSON
Attorney General
of South Carolina
P.O. Box 11549
Columbia, SC 29211

GREG ABBOTT
Attorney General of Texas
P.O. Box 12548
Austin, TX 78711

JAMES D. "BUDDY" CALDWELL
Attorney General
of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804

BILL SCHUETTE
Attorney General
of Michigan
P.O. Box 30212
Lansing, MI 48909

SAMUEL S. OLENS
Attorney General of Georgia
40 Capitol Square, SW
Atlanta, GA 30334

MICHAEL DEWINE
Attorney General of Ohio
30 East Broad Street
17th Floor
Columbus, OH 43215

MATTHEW MEAD
Governor of Wyoming
State Capitol
200 West 24th Street
Cheyenne, WY 82002

WILLIAM J. SCHNEIDER
Attorney General of Maine
Six State House Station
Augusta, ME 04333

JOHN J. BURNS
Attorney General of Alaska
P.O. Box 110300
Juneau, AK 99811

DEREK SCHMIDT
Attorney General of Kansas
Memorial Hall
120 SW 10th Street
Topeka, KS 66612

J.B. VAN HOLLEN
Attorney General of Wisconsin
114 East State Capitol
Madison, WI 53702

TERRY BRANSTAD
Governor of Iowa
107 East Grand Avenue
Des Moines, IA 50319

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Appendix B

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA PENSACOLA DIVISION

Case No.: 3:10-cv-91-RV/EMT

STATE OF FLORIDA, by and through Attorney General Pam Bondi, et al.,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

January 31, 2011

ORDER GRANTING SUMMARY JUDGMENT

On March 23, 2010, President Obama signed health care reform legislation: "The Patient Protection and Affordable Care Act." Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (the "Act").

This case, challenging the Constitutionality of the Act, was filed minutes after the President signed. It has been brought by the Attorneys General and/or Governors of twenty-six states (the "state plaintiffs")[1]; two private citizens (the "individual plaintiffs"); and the National Federation of Independent Business ("NFIB") (collectively, the "plaintiffs"). The defendants are the United States Department of Health and Human Services, the Department of Treasury, the Department of Labor, and their secretaries (collectively, the "defendants"). I emphasized once before, but it bears repeating again: this case is not about whether the Act is wise or unwise legislation, or whether it will solve or exacerbate the myriad problems in our health care system. In fact, it is not really about our health care system at all. It is principally about our federalist system, and it raises very important issues regarding the Constitutional role of the federal government.

James Madison, the chief architect of our federalist system, once famously observed:

> If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place oblige it to control itself.

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[1] The states are Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.

The Federalist No. 51, at 348 (N.Y. Heritage Press ed., 1945) ("*The Federalist*").[2] In establishing our government, the Founders endeavored to resolve Madison's identified "great difficulty" by creating a system of dual sovereignty under which "[t]he powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite." *The Federalist* No. 45, at 311 (Madison); *see also* U.S Const. art. I, § 1 (setting forth the specific legislative powers "herein granted" to Congress). When the Bill of Rights was later added to the Constitution in 1791, the Tenth Amendment reaffirmed that relationship: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

The Framers believed that limiting federal power, and allowing the "residual" power to remain in the hands of the states (and of the people), would help "ensure protection of our fundamental liberties" and "reduce the risk of tyranny and abuse." *See Gregory v. Ashcroft*, 501 U.S. 452, 458, 111 S. Ct.

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[2] *The Federalist* consists of 85 articles or essays written by James Madison, Alexander Hamilton, and John Jay, advocating for ratification of the Constitution. "The opinion of the Federalist has always been considered as of great authority. It is a complete commentary on our constitution; and is appealed to by all parties in the questions to which that instrument has given birth. Its intrinsic merit entitles it to this high rank." *Cohens v. Virginia*, 19 U.S. (6 Wheat) 264, 418, 5 L. Ed. 257 (1821) (Marshall, C.J.). It will be cited to, and relied on, several times throughout the course of this opinion.

2395, 115 L. Ed. 2d 410 (1991) (citation omitted). Very early, the great Chief Justice John Marshall noted "that those limits may not be mistaken, or forgotten, the constitution is written." *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 176, 2 L. Ed. 60 (1803). Over two centuries later, this delicate balancing act continues. Rather than being the mere historic relic of a bygone era, the principle behind a central government with limited power has "never been more relevant than in this day, when accretion, if not actual accession, of power to the federal government seems not only unavoidable, but even expedient." *Brzonkala v. Virginia Polytechnic Institute*, 169 F.3d 820, 826 (4th Cir. 1999) (*en banc*), *aff'd sub nom*, *United States v. Morrison*, 529 U.S. 598, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000).[3]

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[3] In *United States v. Lopez*, 514 U.S. 549, 115 S. Ct. 1624, 131 L. Ed. 2d 626 (1995), a watershed decision that will be discussed infra, the Supreme Court began its analysis by referring to these limits on federal power as "first principles." In a manner of speaking, they may be said to be "last principles" as well, for the *Lopez* Court deemed them to be so important that it also ended its opinion with a full discussion of them. *See id.* at 567-68. Shortly thereafter, in *United States v. Morrison*, 529 U.S. 598, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000), which will also be discussed *infra*, the Supreme Court referred to the division of authority and limits on federal power as the "central principle of our constitutional system." *See id.* at 616 n.7. Clearly, if the modern Supreme Court regards the limits of federal power as first, central, and last principles, those principles are profoundly important — even in this day and age — and they must be treated accordingly in deciding this case.

To say that the federal government has limited and enumerated power does not get one far, however, for that statement is a long-recognized and well-settled truism. *McCulloch v. Maryland*, 17 U.S. (4 Wheat) 316, 405, 4 L. Ed. 579 (1819) ("This government is acknowledged by all, to be one of enumerated powers. The principle, that it can exercise only the powers granted to it, . . . is now universally admitted.") (Marshall, C.J.). The ongoing challenge is deciding whether a particular federal law falls within or outside those powers. It is frequently a difficult task and the subject of heated debate and strong disagreement. As Chief Justice Marshall aptly predicted nearly 200 years ago, while everyone may agree that the federal government is one of enumerated powers, "the question respecting the extent of the powers actually granted, is perpetually arising, and will probably continue to arise, so long as our system shall exist." *Id.* This case presents such a question.

BACKGROUND

The background of this case — including a discussion of the original claims, the defenses, and an overview of the relevant law — is set out in my order dated October 14, 2010, which addressed the defendants' motion to dismiss, and it is incorporated herein. I will only discuss the background necessary to resolving the case as it has been winnowed down to the two causes of action that remain.

In Count I, all of the plaintiffs challenge the "individual mandate" set forth in Section 1501 of the Act, which, beginning in 2014 will require that everyone (with certain limited exceptions) purchase federally-approved health insurance, or pay a monetary penalty.[4] The individual mandate allegedly violates the Commerce Clause, which is the provision of the Constitution Congress relied on in passing it. In Count IV, the state plaintiffs challenge the Act to the extent that it alters and amends the Medicaid program by expanding that program, *inter alia*, to: (i) include individuals under the age of 65 with incomes up to 133% of the federal poverty level, and (ii) render the states responsible for the actual provision of health services thereunder. This expansion of Medicaid allegedly violates the Spending Clause and principles of federalism protected under the Ninth and Tenth Amendments. The plaintiffs seek a declaratory judgment that the Act is unconstitutional and an injunction against its enforcement.

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[4] I previously rejected the defendants' argument that this penalty was really a tax, and that any challenge thereto was barred by the Anti-Injunction Act. My earlier ruling on the defendants' tax argument is incorporated into this order and, significantly, has the effect of focusing the issue of the individual mandate on whether it is authorized by the Commerce Clause. To date, every court to consider this issue (even those that have ruled in favor of the federal government) have also rejected the tax and/or Anti-Injunction arguments. *See Goudy-Bachman v. U.S. Dep't of Health & Human Servs.*, 2011 WL 223010, at *9-*12 (M.D. Pa. Jan. 24, 2011); *Virginia v. Sebelius*, 728 F. Supp. 2d 768, 786-88 (E.D. Va. 2010); *Liberty Univ., Inc. v. Geithner*, — F. Supp. 2d —, 2010 WL 4860299, at *9-*11 (W.D. Va. Nov. 30, 2010); *U.S. Citizens Assoc. v. Sebelius*, — F. Supp. 2d —, 2010 WL 4947043, at *5 (N.D. Ohio Nov. 22, 2010); *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882, 890-91 (E.D. Mich. 2010).

These two claims are now pending on cross motions for summary judgment (docs. 80, 82), which is a pre-trial vehicle through which a party shall prevail if the evidence in the record "shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56. While the parties dispute numerous facts (primarily in the context of the Medicaid count, noted *infra*), they appear to agree that disposition of this case by summary judgment is appropriate — as the dispute ultimately comes down to, and involves, pure issues of law. Both sides have filed strong and well researched memoranda in support of their motions for summary judgment ("Mem."), responses in opposition ("Opp."), and replies ("Reply") in further support. I held a lengthy hearing and oral argument on the motions December 16, 2010 ("Tr."). In addition to this extensive briefing by the parties, numerous organizations and individuals were granted leave to, and did, file *amicus curiae* briefs (sixteen total) in support of the arguments and claims at issue.

I have carefully reviewed and considered all the foregoing materials, and now set forth my rulings on the motions and cross-motions for summary judgment. I will take up the plaintiffs' two claims in reverse order.

DISCUSSION

I. Medicaid Expansion (Count Four)

For this claim, the state plaintiffs object to the fundamental and "massive" changes in the nature and scope of the Medicaid program that the Act will bring about. They contend that the Act violates the

Spending Clause [U.S. Const. art. I, § 8, cl. 1] as it significantly expands and alters the Medicaid program to such an extent they cannot afford the newly-imposed costs and burdens. They insist that they have no choice but to remain in Medicaid as amended by the Act, which will eventually require them to "run their budgets off a cliff." This is alleged to violate the Constitutional spending principles set forth in *South Dakota v. Dole,* 483 U.S. 203, 107 S. Ct. 2793, 97 L. Ed. 2d 171 (1987), and in other cases.[5]

Under *Dole,* there are four restrictions on Congress' Constitutional spending power: (1) the spending must be for the general welfare; (2) the conditions must be stated clearly and unambiguously; (3) the conditions must bear a relationship to the purpose of the program; and 4) the conditions imposed may not require states "to engage in activities that would themselves be unconstitutional." *Supra,* 483 U.S. at 207-10. In addition, a spending condition cannot be "coercive." This conceptional requirement is also from *Dole,* where the Supreme Court speculated (in dicta at the end of that opinion) that "in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *See id.* at 211 (citation omitted). If that line is crossed, the Spending Clause is violated.

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[5] The state plaintiffs alleged in their complaint that the Medicaid provisions also violated the Ninth and Tenth Amendments, but those claims have not been advanced or briefed in their summary judgment motion (except in a single passing sentence, *see* Pl. Mem. at 25).

Preliminarily, I note that in their complaint the state plaintiffs appear to have relied solely on a "coercion and commandeering" theory. Nowhere in that pleading do they allege or intimate that the Act also violates the four "general restrictions" in *Dole*, nor did they make the argument in opposition to the defendants' previous motion to dismiss. Thus, as I stated in my earlier order after describing *Dole's* four general restrictions: "The plaintiffs do not appear to dispute that the Act meets these restrictions. Rather, their claim is based principally on [the coercion theory]." Apparently expanding that argument, the state plaintiffs now argue (very briefly, in less than one full page) that the Act's Medicaid provisions violate the four general restrictions. *See* Pl. Mem. at 44-45. This belated argument is unpersuasive. The Act plainly meets the first three of *Dole's* spending restrictions, and it meets the fourth as long as there is no other required activity that would be independently unconstitutional. Thus, the only real issue with respect to Count IV, as framed in the pleadings, is whether the Medicaid provisions are impermissibly coercive and effectively commandeer the states.

The gist of this claim is that because Medicaid is the single largest federal grant-in-aid program to the states, and because the states and the needy persons receiving that aid have come to depend upon it, the state plaintiffs are faced with an untenable Hobson's Choice. They must either (1) accept the Act's transformed Medicaid program with its new costs and obligations, which they cannot afford, or (2) exit the program altogether and lose the federal matching funds that are necessary and essential to provide health care coverage to their neediest citizens (along with other Medicaid-linked federal funds). Either way, they contend that their state Medicaid systems will eventually collapse, leaving millions of their neediest residents without health care. The state plaintiffs assert that they effectively have no choice other than to participate in the program.

In their voluminous materials filed in support of their motion for summary judgment, the state plaintiffs have identified some serious financial and practical problems that they are facing under the Act, especially its costs. They present a bleak fiscal picture. At the same time, much of those facts have been disputed by the defendants in their equally voluminous filings; and also by some of the states appearing in the case as *amici curiae*, who have asserted that the Act will in the long run save money for the states. It is simply impossible to resolve this factual dispute now as both sides' financial data are based on economic assumptions, estimates, and projections many years out. In short, there are numerous genuine disputed issues of material fact with respect to this claim that cannot be resolved on summary judgment.[6] However, even looking beyond these presently impossible-to-resolve disputed issues of fact, there is simply no support for the state plaintiffs' coercion argument in existing case law.

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[6] Perhaps anticipating this, the state plaintiffs maintained in response to the defendants' filings that "the entire question of whether the States' costs might to some extent be offset by collateral savings is legally irrelevant." *See* Pl. Opp. at 29. Thus, "even if the States were projected to achieve collateral savings, those savings would in no way lessen the coercion and

In considering this issue at the motion to dismiss stage, I noted that state participation in the Medicaid program under the Act is — as it always has been — voluntary. This is a fundamental binary element: it either is voluntary, or it is not. While the state plaintiffs insist that their participation is involuntary, and that they cannot exit the program, the claim is contrary to the judicial findings in numerous other Medicaid cases [*see, e.g.*, *Wilder v. Virginia Hosp. Assoc.*, 496 U.S. 498, 502, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990) (observing that "Medicaid is a cooperative federal-state program [and] participation in the program is voluntary"); *Florida Assoc. of Rehab. Facilities v. Florida Dep't of*

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commandeering of which Plaintiff States complain, because they would still be required to do Congress's bidding." *Id.* at 41-42. However, it would appear from the operative complaint that the coercion claim has always been rooted in the underlying contention that the Act forces the states to expend resources that they cannot afford: "Plaintiff States cannot afford the unfunded costs of participating under the Act, but effectively have no choice other than to participate." Second Amended Complaint at ¶ 84; *see also id.* at ¶ 86 (referring to the "fiscal impact" of the Medicaid expansion and explaining that it will compel states "to assume costs they cannot afford"); *id.* at ¶ 41 (Act will "expand eligibility for enrollment beyond the State's ability to fund its participation"); id. at ¶ 56 (referring to the projected billions of dollars in additional costs "stemming from the Medicaid-related portions of the Act" which will "grow in succeeding years"); *id.* at ¶ 66 (referencing the "harmful effects of the Act on [the state] fiscs").

Health & Rehab. Servs, 225 F.3d 1208, 1211 (11th Cir. 2000) ("No state is obligated to participate in the Medicaid program."); *Doe v. Chiles*, 136 F.3d 709, 722 (11th Cir. 1998) (Medicaid is a program from which the state "always retains [the] option" to withdraw)], and belied by numerous published news reports that several states (including certain of the plaintiffs in this case) are presently considering doing exactly that. Furthermore, two plaintiff states have acknowledged in declarations filed in support of summary judgment that they can withdraw from the program. *See* Declaration of Michael J. Willden (Director of Department of Health and Human Services, Nevada) ("Nevada can still consider opting out of Medicaid a viable option."); Declaration of Deborah K. Bowman (Secretary of Department of Social Services, South Dakota) (conceding that although it would be detrimental to its Medicaid recipients, South Dakota could "cease participation in the Medicaid Program"). When the freedom to "opt out" of the program is viewed in light of the fact that Congress has expressly reserved the right to alter or amend the Medicaid program [*see* 42 U.S.C. § 1304 ("The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress.")], and has done so many times over the years, I observed in my earlier order that the plaintiffs' argument was not strong. *See Harris v. McRae*, 448 U.S. 297, 301, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980) (stating that "participation in the Medicaid program is entirely optional, [but] once a State elects to participate, it must comply with the requirements").

Indeed, a survey of the legal landscape revealed that there was "very little support for the plaintiffs' coercion theory argument" as every single federal Court of Appeals called upon to consider the issue has rejected the coercion theory as a viable claim. *See, e.g., Doe v. Nebraska*, 345 F.3d 593, 599-600 (8th Cir. 2003); *Kansas v. United States*, 214 F.3d 1196, 1201-02 (10th Cir. 2000); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997); *Oklahoma v. Schweiker*, 655 F.2d 401, 413-14 (D.C. Cir. 1981); *State of New Hampshire Dep't of Employment Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980); but see *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 288-90 (4th Cir. 2002) (referring to a prior decision of that court, *Commonwealth of Virginia Dep't of Education v. Riley*, 106 F.3d 559 (4th Cir. 1997), where six of the thirteen judges on an en banc panel stated in dicta that a coercion claim may be viable in that court, but going on to note that due to "strong doubts" about the viability of the coercion theory "most courts faced with the question have effectively abandoned any real effort to apply the coercion theory" after finding, in essence, that it "raises political questions that cannot be resolved by the courts").

In the absence of an Eleventh Circuit case on point, the state plaintiffs' claim was "plausible" at the motion to dismiss stage. Thus, the plaintiffs were allowed to proceed and provide evidentiary support and further legal support for a judicially manageable standard or coherent theory for determining when, in the words of the Supreme Court, a federal spending condition "pass[es] the point at which 'pressure turns into compulsion.'" *See Dole, supra,* 483 U.S. at 211. The evidentiary support is substantially in dispute, as already noted, and further legal support has not been forthcoming. It is now apparent that existing case law is inadequate to support the state plaintiffs' coercion claim. As the Ninth Circuit has explained in its analysis of an earlier coercion claim made by the State of Nevada:

> We can hardly fault appellant [for not providing the court with any principled definition of the word "coercion"] because our own inquiry has left us with only a series of unanswered questions. Does the relevant inquiry turn on how high a percentage of the total programmatic funds is lost when federal aid is cut-off? Or does it turn, as Nevada claims in this case, on what percentage of the federal share is withheld? Or on what percentage of the state's total income would be required to replace those funds? Or on the extent to which alternative private, state, or federal sources of . . . funding are available? There are other interesting and more fundamental questions. For example, should the fact that Nevada, unlike most states, fails to impose a state income tax on its residents play a part in our analysis? Or, to put the question more basically, can a sovereign state which is always free to increase its tax revenues ever be coerced by the withholding of federal funds — or is the state merely presented with hard political choices?

Nevada v. Skinner, 884 F.2d 445, 448 (9th Cir. 1989). It is not simply a matter of these being generally difficult or complex questions for courts to resolve because, as I have said, "courts deal every day with the difficult complexities of applying Constitutional principles set forth and defined by the Supreme Court." Rather, as Justice Cardozo cautioned in what appears to have been the first case to hint at the possibility of a coercion theory claim, "to hold that motive or temptation is equivalent to coercion is to plunge the law in *endless* difficulties." *See Steward Machine Co. v. Davis*, 301 U.S. 548, 589-90, 57 S. Ct. 883, 81 L. Ed. 1279 (1937) (emphasis added); *see also, e.g., Skinner, supra*, 884 F.2d at 448 ("The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments.").

In short, while the plaintiffs' coercion theory claim was plausible enough to survive dismissal, upon full consideration of the relevant law and the Constitutional principles involved, and in light of the numerous disputed facts alluded to above, I must conclude that this claim cannot succeed and that the defendants are entitled to judgment as a matter of law. In so ruling, I join all courts to have considered this issue and reached the same result, even in factual situations that involved (as here) the potential withdrawal of a state's entire Medicaid grant. *See, e.g., Schweiker, supra,* 655 F.2d at 414 ("The courts are not suited to evaluating whether the states are faced here with an offer they cannot refuse or merely a hard choice."); *California, supra*, 104 F.3d at 1086 (rejecting coercion theory argument based on the claim that while the state joined Medicaid voluntarily, it had grown to depend on federal funds and "now has no choice but to remain in the program in order to prevent a collapse of its medical system").

I appreciate the difficult situation in which the states find themselves. It is a matter of historical fact that at the time the Constitution was drafted and ratified, the Founders did not expect that the federal government would be able to provide sizeable funding to the states and, consequently, be able to exert power over the states to the extent that it currently does. To the contrary, it was expected that the federal government would have limited sources of tax and tariff revenue, and might have to be supported by the states. This reversal of roles makes any state federal partnership somewhat precarious given the federal government's enormous economic advantage. Some have suggested that, in the interest of federalism, the Supreme Court should revisit and reconsider its Spending Clause cases. *See* Lynn A. Baker, *The Spending Power and the Federalist Revival*, 4 Chap. L. Rev. 195-96 (2001) (maintaining the "greatest threat to state autonomy is, and has long been, Congress's spending power" and "the states will be at the mercy of Congress so long as there are no meaningful limits on its spending power"). However, unless and until that happens, the states have little recourse to remaining the very junior partner in this partnership.

Accordingly, summary judgment must be granted in favor of the defendants on Count IV.

II. Individual Mandate (Count One)

For this claim, the plaintiffs contend that the individual mandate exceeds Congress' power under the Commerce Clause. To date, three district courts have ruled on this issue on the merits. Two have held that the individual mandate is a proper exercise of the commerce power [*Liberty Univ., Inc. v. Geithner*, — F. Supp. 2d —, 2010 WL 4860299 (W.D. Va. Nov. 30, 2010); *Thomas More Law Center v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010)], while the other court held that it violates the Commerce Clause. *Virginia v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010).

At issue here, as in the other cases decided so far, is the assertion that the Commerce Clause can only reach individuals and entities engaged in an "activity"; and because the plaintiffs maintain that an individual's failure to purchase health insurance is, almost by definition, "inactivity," the individual mandate goes beyond the Commerce Clause and is unconstitutional. The defendants contend that activity is not required before Congress can exercise its Commerce Clause power, but that, even if it is required, not having insurance constitutes activity. The defendants also claim that the individual mandate is sustainable for the "second reason" that it falls within the Necessary and Proper Clause.[7]

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[7] The Necessary and Proper Clause is not really a separate inquiry, but rather is part and parcel of the Commerce Clause analysis as it augments that enumerated power by authorizing Congress "To make all Laws which shall be necessary and proper" to regulate interstate commerce. *See, e.g., Gonzales v. Raich*, 545 U.S. 1, 22, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005); *see also id.* at 34-35, 39 (Scalia, J., concurring in judgment); *accord Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1249 (11th Cir. 2008) (the Commerce Clause power is "the combination of the Commerce Clause per se and the

A. Standing to Challenge the Individual Mandate

Before addressing the individual mandate, I must first take up the issue of the plaintiffs' standing to pursue this claim. I previously held on the motion to dismiss that the individual plaintiffs and NFIB had standing, but the defendants have re-raised the issue on summary judgment.[8]

One of the individual plaintiffs, Mary Brown, has filed a declaration in which she avers, among other things: (i) that she is a small business owner and member of NFIB; (ii) that she does not currently have health insurance and has not had health insurance for the past four years; (iii) that she regularly uses her personal funds to meet her business expenses; (iv) that she is not eligible for Medicaid or Medicare and will not be eligible in 2014; (v) that she is subject to the individual mandate and objects to being required to comply as she does not believe the cost of health insurance is a wise or acceptable use of her resources; (vi) that both

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Necessary and Proper Clause"). Nevertheless, I will consider the two arguments separately for ease of analysis, and because that is how the defendants have framed and presented their arguments. *See* Def. Mem. at 23 (contending that the individual mandate is an essential part of the regulatory health care reform effort, and is thus "also a valid exercise of Congress's authority if the provision is analyzed under the Necessary and Proper Clause").

[8] It was not necessary to address standing for the Medicaid challenge as the defendants did not dispute that the states could pursue that claim.

she and her business will be harmed if she is required to buy health insurance that she neither wants nor needs because it will force her to divert financial resources from her other priorities, including running her business, and doing so will "threaten my ability to maintain my own, independent business"; (vii) that she would be forced to reorder her personal and business affairs because, "[w]ell in advance of 2014, I must now investigate whether and how to both obtain and maintain the required insurance"; and lastly, (viii) that she "must also now investigate the impact" that compliance with the individual mandate will have on her priorities and whether she can maintain her business, or whether, instead, she will have to lay off employees, close her business, and seek employment that provides qualifying health insurance as a benefit.

The other individual plaintiff, Kaj Ahlburg, has filed a declaration in which he avers, *inter alia*: (i) that he is retired and holds no present employment; (ii) that he has not had health care insurance for the past six years; (iii) that he has no desire or intention to buy health insurance as he is currently, and expects to remain, able to pay for his and his family's own health care needs; (iv) that he is not eligible for Medicaid or Medicare and will not be eligible in 2014; (v) that he is subject to the individual mandate and he objects to being forced to comply with it as it does not represent "a sensible or acceptable use of my financial resources" and will force him "to divert funds from other priorities which I know to be more important for myself and my family"; and (vi) that he "must now investigate" how and whether to rearrange his finances "to ensure the availability of sufficient funds" to pay for the required insurance premiums.

These declarations are adequate to support standing for the reasons set forth and discussed at length in my prior opinion, which need not be repeated here in any great detail. To establish standing to challenge a statute, a plaintiff needs to show "a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement" [*Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298, 99 S. Ct. 2301, 60 L. Ed. 2d 895 (1979)]; that is "pegged to a sufficiently fixed period of time" [*ACLU of Florida, Inc. v. Miami-Dade County School Bd.*, 557 F.3d 1177, 1194 (11th Cir. 2009)]; and which is not "merely hypothetical or conjectural" [*Florida State Conference of the NAACP v. Browning*, 522 F.3d 1153, 1161 (11th Cir. 2008)]. The individual plaintiffs, Ms. Brown in particular, have established that because of the financial expense they will definitively incur under the Act in 2014, they are needing to take investigatory steps and make financial arrangements now to ensure compliance then. That is enough to show standing, as the clear majority of district courts to consider legal challenges to the individual mandate have held. *See Goudy-Bachman v. U.S. Dep't of Health & Human Servs.*, 2011 WL 223010, at *4-*7 (M.D. Pa. Jan. 24, 2011); *Liberty Univ., Inc., supra*, 2010 WL 4860299, at *5-*7; *U.S. Citizens Assoc., supra*, 2010 WL 4947043, at *3; *Thomas More Law Center, supra*, 720 F. Supp. 2d 882, 887-89; *but see Baldwin v. Sebelius*, 2010 WL 3418436, at *3 (S.D. Cal. Aug. 27, 2010) (holding that plaintiff in that case lacked standing to challenge individual mandate on the grounds that by 2014 he may have secured insurance on his own). As the District Court for the Eastern District of Michigan properly noted in *Thomas More Law Center* (a case on which the defendants heavily rely because it ultimately upheld the individual mandate): "[T]he government is requiring plaintiffs to undertake an expenditure, for which the government must anticipate that significant financial planning will be required. That financial planning must take place well in advance of the actual purchase of insurance in 2014 . . . There is nothing improbable about the contention that the Individual Mandate is causing plaintiffs to feel economic pressure today." *Thomas More Law Center*, *supra*, 720 F. Supp. 2d at 889.[9]

Because the individual plaintiffs have demonstrated standing, including NFIB member Mary Brown, that means (as also discussed in my earlier order) that NFIB has associational standing as well. This leaves the question of the state plaintiffs' standing to contest the individual mandate — an issue which was not necessary to reach on the motion to dismiss, but which the plaintiffs request that I address now.

The state plaintiffs have raised several different grounds for standing. One of those grounds is that some of the states have passed legislation seeking to protect their citizens from forced compliance with the individual mandate. For example, on March 17, 2010, before the Act passed into law, plaintiff Idaho enacted the Idaho Health Freedom Act, which provides in pertinent part:

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[9] I note that *Thomas More Law Center* is on appeal to the Sixth Circuit, and in their recently-filed appellate brief the Department of Justice has expressly declined to challenge the district court's conclusion that the plaintiffs had standing.

> (1) The power to require or regulate a person's choice in the mode of securing health care services, or to impose a penalty related thereto, is not found in the Constitution of the United States of America, and is therefore a power reserved to the people pursuant to the Ninth Amendment, and to the several states pursuant to the Tenth Amendment. The state of Idaho hereby exercises its sovereign power to declare the public policy of the state of Idaho regarding the right of all persons residing in the state of Idaho in choosing the mode of securing health care services free from the imposition of penalties, or the threat thereof, by the federal government of the United States of America relating thereto.
>
> (2) It is hereby declared that . . . every person within the state of Idaho is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty by the federal government of the United States of America.

I.C. § 39-9003 (2010).

Similarly, on March 22, 2010, also before the Act became law, Utah passed legislation declaring that the then-pending federal government proposals for health care reform "infringe on state powers" and "infringe on the rights of citizens of this state to provide for their own health care" by "requiring a person to enroll in a third party payment system" and "imposing fines on a person who chooses to pay directly for health care rather than use a third party payer." *See generally* U.C.A. 1953 § 63M-1-2505.5.

Judge Henry Hudson considered similar legislation in one of the two Virginia cases. After engaging in a lengthy analysis and full discussion of the applicable law [*see generally Virginia v. Sebelius*, 702 F. Supp. 2d 598, 602-07 (E.D. Va. 2010)], he concluded that despite the statute's declaratory nature, the Commonwealth had adequate standing to bring the suit insofar as "[t]he mere existence of the lawfully enacted statue is sufficient to trigger the duty of the Attorney General of Virginia to defend the law and the associated sovereign power to enact it." *See id.* at 605-06. I agree with Judge Hudson's thoughtful analysis of the issue and adopt it here. The States of Idaho and Utah, through plaintiff Attorneys General Lawrence G. Wasden and Mark L. Shurtleff, have standing to prosecute this case based on statutes duly passed by their legislatures, and signed into law by their Governors.[10]

In sum, the two individual plaintiffs (Brown and Ahlburg), the association (NFIB), and at least two of the states (Idaho and Utah) have standing to challenge the individual mandate. This eliminates the need to discuss the standing issue with respect to the other state plaintiffs, or the other asserted bases for standing. *See Watt v. Energy Action Educ. Found.*, 454 U.S. 151, 160, 102 S. Ct. 205, 70 L. Ed. 2d 309 (1981) ("Because we find California has standing, we do not consider the standing of the other plaintiffs."); *Village of Arlington Heights v. Metropolitan Housing Dev. Corp.*, 429 U.S. 252, 264 n.9, 97 S. Ct. 555, 50 L. Ed. 2d 450 (1977) ("Because of the presence of this plaintiff, we need not consider whether the other individual and corporate plaintiffs have standing to maintain this suit."); *see also Mountain States Legal Foundation v. Glickman*, 92 F.3d 1228, 1232 (D.C. Cir. 1996) (if standing is shown for at least one plaintiff with respect to each claim, "we need not consider the standing of the other plaintiffs to raise that claim").

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[10] I note that several other plaintiff states passed similar laws after the Act became law and during the pendency of this litigation. Other states have similar laws still pending in their state legislatures.

Having reaffirmed that the plaintiffs have adequate standing to challenge the individual mandate, I will consider whether that provision is an appropriate exercise of power under the Commerce Clause, and, if not, whether it is sustainable under the Necessary and Proper Clause. The Constitutionality of the individual mandate is the crux of this entire case.

B. Analysis

(1) The Commerce Clause

The current state of Commerce Clause law has been summarized and defined by the Supreme Court on several occasions:

> [W]e have identified three broad categories of activity that Congress may regulate under its commerce power. First, Congress may regulate

> the use of the channels of interstate commerce. Second, Congress is empowered to regulate and protect the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities. Finally, Congress' commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce, i.e., those activities that substantially affect interstate commerce.

United States v. Lopez, 514 U.S. 549, 558-59, 115 S. Ct. 1624, 131 L. Ed. 2d 626 (1995) (citations omitted); *accord United States v. Morrison*, 529 U.S. 598, 608-09, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000); *see also Hodel v. Virginia Surface Min. & Reclamation Assoc., Inc.*, 452 U.S. 264, 276-77, 101 S. Ct. 2352, 69 L. Ed. 2d 1 (1981); *Perez v. United States*, 402 U.S. 146, 150, 91 S. Ct. 1357, 28 L. Ed. 2d 686 (1971). It is thus well settled that Congress has the authority under the Commerce Clause to regulate three — and only three — "categories of activity." *Lopez, supra*, 514 U.S. at 558; *see also, e.g., Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1249-51 (11th Cir. 2008) (discussing in detail the "three categories of activities" that Congress can regulate); *United States v. Maxwell*, 446 F.3d 1210, 1212 (11th Cir. 2006) (noting that, "to date," Congress can regulate only "three categories of activities"). The third category is the one at issue in this case.

As will be seen, the "substantially affects" category is the most frequently disputed and "most hotly contested facet of the commerce power."

Garcia, supra, 540 F.3d at 1250. This is because, while under the first two categories Congress may regulate and protect actual interstate commerce,

> the third allows Congress to regulate intrastate noncommercial activity, based on its effects. Consideration of effects necessarily involves matters of degree [and] thus poses not two hazards, like Scylla and Charybdis, but three. If we entertain too expansive an understanding of effects, the Constitution's enumeration of powers becomes meaningless and federal power becomes effectively limitless. If we entertain too narrow an understanding, Congress is stripped of its enumerated power, reinforced by the Necessary and Proper Clause, to protect and control commerce among the several states. If we employ too nebulous a standard, we exacerbate the risk that judges will substitute their own subjective or political calculus for that of the elected representatives of the people, or will appear to be doing so.

United States v. Patton, 451 F.3d 615, 622-23 (10th Cir. 2006). Before attempting to navigate among these three "hazards," a full review of the historical roots of the commerce power, and a discussion of how we got to where we are today, may be instructive.

(a) The Commerce Clause in its Historical Context

Chief Justice Marshall wrote in 1824, in the first ever Commerce Clause case to reach the Supreme Court:

> As men, whose intentions require no concealment, generally employ the words which most directly and aptly express the ideas they intend to convey, the enlightened patriots who framed our constitution, and the people who adopted it, must be understood to have employed words in their natural sense, and to have intended what they have said.

Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 188, 6 L. Ed. 23 (1824). Justice Marshall continued his opinion by noting that if, "from the imperfection of human language," there are doubts as to the extent of any power authorized under the Constitution, the underlying object or purpose for which that power was granted "should have great influence in the construction." *Id.* at 188-89. In other words, in determining the full extent of any granted power, it may be helpful to not only focus on *what* the Constitution says (i.e., the actual language used), but also *why* it says what it says (i.e., the problem or issue it was designed to address). Both will be discussed in turn.

The Commerce Clause is a mere sixteen words long, and it provides that Congress shall have the power:

> To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.

U.S. Const. art I, § 8, cl. 3. For purposes of this case, only seven words are relevant: "To regulate Commerce . . . among the several States." There is considerable historical evidence that in the early years of the Union, the word "commerce" was understood to encompass trade, and the intercourse, traffic, or exchange of goods; in short, "the activities of buying and selling that come after production and before the goods come to rest." Robert H. Bork & Daniel E. Troy, *Locating the Boundaries: The Scope of Congress's Power to Regulate Commerce*, 25 Harv. J. L. & Pub. Pol'y 849, 861-62 (2002) ("Bork & Troy") (citing, *inter alia*, dictionaries from that time which defined commerce as "exchange of one thing for another"). In a frequently cited law review article, one Constitutional scholar has painstakingly tallied each appearance of the word "commerce" in Madison's notes on the Constitutional Convention and in *The Federalist*, and discovered that in none of the ninety-seven appearances of that term is it ever used to refer unambiguously to activity beyond trade or exchange. *See* Randy E. Barnett, *The Original Meaning of the Commerce Clause*, 68 U. Chi. L. Rev. 101, 114-16 (2001) ("Barnett"); *see also id.* at 116 (further examining each and every use of the word that appeared in the state ratification convention reports and finding "the term was uniformly used to refer to trade or exchange"). Even a Constitutional scholar who has argued for an expansive interpretation of the Commerce Clause (and, in fact, has been cited to, and relied on, by the defendants in this case) has acknowledged that when the Constitution was drafted and ratified, commerce "was the practical equivalent of the word 'trade.'" *See* Robert L. Stern, *That Commerce Which Concerns More States than One*, 47 Harv. L. Rev. 1335, 1346 (1934) ("Stern").

The Supreme Court's first description of commerce (and still the most widely accepted) is from *Gibbons v. Ogden*, *supra*, which involved a New York law that sought to limit the navigable waters within the jurisdiction of that state. In holding that "commerce" comprehended navigation, and thus it fell within the reach of the Commerce Clause, Chief Justice Marshall explained that "Commerce, undoubtedly, is traffic, but it is something more: it is intercourse. It describes the commercial intercourse between nations, and parts of nations, in all its branches, and is regulated by prescribing rules for carrying on that intercourse." 22 U.S. at 72. This definition is consistent with accepted dictionary definitions of the Founders' time. *See* 1 Samuel Johnson, *A Dictionary of the English Language* (4th ed. 1773) (commerce defined as "Intercourse; exchange of one thing for another; interchange of any thing; trade; traffick"). And it remained a good definition of the Supreme Court's Commerce Clause interpretation throughout the Nineteenth Century. *See, e.g., Kidd v. Pearson,* 128 U.S. 1, 20-21, 9 S. Ct. 6, 32 L. Ed. 346 (1888) ("The legal definition of the term [commerce] . . . consists in intercourse and traffic, including in these terms navigation and the transportation and transit of persons and property, as well as the purchase, sale, and exchange of commodities"). As Alexander Hamilton intimated in *The Federalist*, however, it did not at that time encompass manufacturing or agriculture. *See The Federalist* No. 34, at 212-13 (noting that the "encouragement of agriculture and manufactures" was to remain an object of state expenditure). This interpretation of commerce as being primarily concerned with the commercial intercourse associated with the trade or exchange of goods and commodities is consistent with the original purpose of the Commerce Clause (discussed immediately below), which is entitled to "great influence in [its] construction." *See Gibbons, supra,* 22 U.S. at 188-89.[11]

There is no doubt historically that the primary purpose behind the Commerce Clause was to give Congress power to regulate commerce so that it could eliminate the trade restrictions and barriers by and between the states that had existed under the

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[11] As an historical aside, I note that pursuant to this original understanding and interpretation of "commerce," insurance contracts did not qualify because "[i]ssuing a policy of insurance is not a transaction of commerce." *Paul v. Virginia,* 75 U.S. (8 Wall.) 168, 183, 19 L. Ed. 357 (1868) (further explaining that insurance contracts "are not articles of commerce in any proper meaning of the word" as they are not objects "of trade and barter," nor are they "commodities to be shipped or forwarded from one State to another, and then put up for sale"). That changed in 1944, when the Supreme Court held that Congress could regulate the insurance business under the Commerce Clause. *United States v. South-Eastern Underwriters Assoc.,* 322 U.S. 533, 64 S. Ct. 1162, 88 L. Ed. 1440 (1944). "Concerned that [this] decision might undermine state efforts to regulate insurance, Congress in 1945 enacted the McCarran-Ferguson Act. Section 1 of the Act provides that 'continued regulation and taxation by the several States of the business of insurance is in the public interest,' and that 'silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.'" *Humana Inc. v. Forsyth,* 525 U.S. 299, 306, 119 S. Ct. 710, 142 L. Ed.2d 753 (1999) (quoting 15 U.S.C. § 1011). Thus, ever since passage of the McCarran-Ferguson Act, the insurance business has continued to be regulated almost exclusively by the states.

Articles of Confederation. Such obstructions to commerce were destructive to the Union and believed to be precursors to war. The Supreme Court has explained this rationale:

> When victory relieved the Colonies from the pressure for solidarity that war had exerted, a drift toward anarchy and commercial warfare between states began . . . [E]ach state would legislate according to its estimate of its own interests, the importance of its own products, and the local advantages or disadvantages of its position in a political or commercial view. This came to threaten at once the peace and safety of the Union. The sole purpose for which Virginia initiated the movement which ultimately produced the Constitution was to take into consideration the trade of the United States; to examine the relative situations and trade of the said states; to consider how far a uniform system in their commercial regulation may be necessary to their common interest and their permanent harmony and for that purpose the General Assembly of Virginia in January of 1786 named commissioners and proposed their meeting with those from other states.
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> The desire of the Forefathers to federalize regulation of foreign and interstate commerce stands in sharp contrast to their jealous preservation of power over their internal affairs. No other federal power was so universally assumed to be necessary, no other state power was so readily relin[q]uished. There was no desire to authorize federal interference with social conditions or legal institutions of the

> states. Even the Bill of Rights amendments were framed only as a limitation upon the powers of Congress. The states were quite content with their several and diverse controls over most matters but, as Madison has indicated, "want of a general power over Commerce led to an exercise of this power separately, by the States, which not only proved abortive, but engendered rival, conflicting and angry regulations."

H.P. Hood & Sons, Inc. v. Du Mond, 336 U.S. 525, 533-34, 69 S. Ct. 657, 93 L. Ed. 865 (1949) (citations and quotations omitted). The foregoing is a frequently repeated history lesson from the Supreme Court. In his concurring opinion in the landmark 1824 case of *Gibbons v. Ogden*, supra, for example, Justice Johnson provided a similar historical summary:

> For a century the States [as British colonies] had submitted, with murmurs, to the commercial restrictions imposed by the parent State; and now, finding themselves in the unlimited possession of those powers over their own commerce, which they had so long been deprived of, and so earnestly coveted, that selfish principle which, well controlled, is so salutary, and which, unrestricted, is so unjust and tyrannical, guided by inexperience and jealousy, began to show itself in iniquitous laws and impolitic measures, from which grew up a conflict of commercial regulations, destructive to the harmony of the States, and fatal to their commercial interests abroad.

> This was the immediate cause, that led to the forming of a convention.

Gibbons, supra, 22 U.S. at 224. In the Supreme Court's 1888 decision in *Kidd v. Pearson,* Justice Lamar noted that "it is a matter of public history that the object of vesting in congress the power to regulate commerce . . . among the several states was to insure uniformity for regulation against conflicting and discriminatory state legislation." *See Kidd, supra,* 128 U.S. at 21. More recently, Justice Stevens has advised that when "construing the scope of the power granted to Congress by the Commerce Clause . . . [i]t is important to remember that this clause was the Framers' response to the central problem that gave rise to the Constitution itself," that is, the Founders had "'set out only to find a way to reduce trade restrictions.'" *See EEOC v. Wyoming,* 460 U.S. 226, 244-45, 103 S. Ct. 1054, 75 L. Ed. 2d 18 (1983) (Stevens, J., concurring). The foregoing history is so "widely shared," [*see id.* at 245 n.1], that Constitutional scholars with opposing views on the Commerce Clause readily agree on this point. *Compare* Stern, *supra,* at 1344 ("There can be no question, of course, that in 1787 [when] the framers and ratifiers of the Constitution . . . considered the need for regulating 'commerce with foreign nations and among the several states,' they were thinking only in terms of . . . the removal of barriers obstructing the physical movements of goods across state lines."), *with* Bork & Troy, *supra,* at 858, 865 ("One thing is certain: the Founders turned to a federal commerce power to carve stability out of this commercial anarchy" and "keep the States from treating one another as hostile foreign powers"; in short, "the Clause was drafted to grant Congress the power to craft a coherent national trade policy, to restore and maintain viable trade among the states, and to prevent interstate war."). Hamilton and Madison both shared this concern that conflicting and discriminatory state trade legislation "would naturally lead to outrages, and these to reprisals and wars." *The Federalist* No. 7, at 37 (Hamilton); *see also The Federalist* No. 42, at 282 (Madison) (referencing the "unceasing animosities" and "serious interruptions of the public tranquility" that would inevitably flow from the lack of national commerce power).

To acknowledge the foregoing historical facts is not necessarily to say that the power under the Commerce Clause was intended to (and must) remain limited to the trade or exchange of goods, and be confined to the task of eliminating trade barriers erected by and between the states.[12] The drafters of the Constitution were aware that they were preparing an instrument for the ages, not one suited only for the exigencies of that particular time.

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[12] Although there is some evidence that is exactly what Madison, at least, had intended. In one of his letters, he wrote that the Commerce Clause "'grew out of the abuse of the power by the importing States in taxing the non-importing, and was intended as a negative and preventive provision against injustice among the States themselves, rather than as a power to be used for the positive purposes of the General Government.'" *West Lynn Creamery, Inc. v. Healy*, 512 U.S. 186, 193 n.9, 114 S. Ct. 2205, 129 L. Ed. 2d 157 (1994) (quoting 3 M. Farrand, Records of the Federal Convention of 1787, p. 478 (1911)).

See, e.g., *McCulloch*, *supra*, 17 U.S. at 415 (the Constitution was "intended to endure for ages to come" and "to be adapted to the various crises of human affairs") (Marshall, C.J.); *Weems v. United States*, 217 U.S. 349, 373, 30 S. Ct. 544, 54 L. Ed. 793 (1910) (explaining that constitutions "are not ephemeral enactments, designed to meet passing occasions," but rather are "designed to approach immortality as nearly as human institutions can approach it . . . [and], therefore, our contemplation cannot be only of what has been, but of what may be"); accord *New York v. United States*, 505 U.S. 144, 157, 112 S. Ct. 2408, 120 L. Ed. 2d 120 (1992) (the Constitution was "phrased in language broad enough to allow for the expansion" of federal power and allow "enormous changes in the nature of government"). As Hamilton explained:

> Constitutions of civil government are not to be framed upon a calculation of existing exigencies, but upon a combination of these with the probable exigencies of ages, according to the natural and tried course of human affairs. Nothing, therefore, can be more fallacious than to infer the extent of any power, proper to be lodged in the national government, from an estimate of its immediate necessities. There ought to be a *capacity* to provide for future contingencies as they may happen; and as these are illimitable in their nature, it is impossible safely to limit that capacity.

The Federalist No. 34, at 210-11 (emphasis in original).

Thus, the exercise and interpretation of the commerce power has evolved and undergone a significant change "as the needs of a dynamic and constantly expanding national economy have changed." *See EEOC, supra,* 460 U.S. at 246 (Stevens, J., concurring). But, I will begin at the beginning.

(b) Evolution of Commerce Clause Jurisprudence

Some have maintained that the Commerce Clause power began as, and was intended to remain, a narrow and limited one. *See, e.g.,* Raoul Berger, *Federalism: The Founders Design* (1987) (arguing that the founders sought to create a limited federal government whose power, including the commerce power, was narrow in scope); Barnett, *supra,* at 146 (concluding that "the most persuasive evidence of original meaning . . . strongly supports [the] narrow interpretation of Congress's power [under the Commerce Clause]"). Despite evidence to support this position, it is difficult to prove decisively because for the first century of our history the Clause was seldom invoked by Congress (if at all), and then only negatively to prevent the interference with commerce by individual states. This necessarily means that there is a lack of early congressional and judicial pronouncements on the subject. This, in turn, makes it harder to conclusively determine how far the commerce power was originally intended to reach. It was not until 1824 (more than three decades after ratification) that the Supreme Court was first called upon in *Gibbons v. Ogden* to consider the commerce power. By that time, it would appear that the Clause was given a rather expansive treatment by Chief Justice Marshall, who wrote:

> [The commerce power] is the power to regulate; that is, to prescribe the rule by which commerce is to be governed. This power, like all others vested in Congress, is complete in itself, may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution . . . If, as has always been understood, the sovereignty of Congress, though limited to specified objects, is plenary as to those objects, the power over commerce with foreign nations, and among the several States, is vested in Congress as absolutely as it would be in a single government, having in its constitution the same restrictions on the exercise of the power as are found in the constitution of the United States. The wisdom and the discretion of Congress, their identity with the people, and the influence which their constituents possess at elections, are, in this, as in many other instances . . . the sole restraints on which they have relied, to secure them from its abuse.

Gibbons, supra, 22 U.S. at 75. Notwithstanding this seemingly broad interpretation of Congress' power to negate New York's assertion of authority over its navigable waters, it was not until 1887, one hundred years after ratification, that Congress first exercised its power to affirmatively and positively regulate commerce among the states. And when it did, the Supreme Court at that time rejected the broad conception of commerce and the power of Congress to regulate the economy was sharply restricted. *See, e.g., Kidd v. Pearson, supra* (1888). Thus, for most of the first century and a half of Constitutional government (with the possible exception of *Gibbons v. Ogden* in 1824), the Clause was narrowly construed and given "miserly construction." *See EEOC, supra,* 460 U.S. at 246 (Stevens, J., concurring) (citing *Kidd, supra,* 128 U.S. at 20-21 (manufacturing not subject to the commerce power of Congress); *United States v. E.C. Knight Co.*, 156 U.S. 1, 12-16, 15 S. Ct. 249, 39 L. Ed. 325 (1895) (manufacturing monopoly not subject to commerce power); *Adair v. United States*, 208 U.S. 161, 178-179, 28 S. Ct. 277, 52 L. Ed. 436 (1908) (connection between interstate commerce and membership in a labor union insufficient to authorize Congress to make it a crime for an interstate carrier to fire employee for his union membership); *Hammer v. Dagenhart*, 247 U.S. 251, 276, 38 S. Ct. 529, 62 L. Ed. 1101 (1918) (Congress without power to prohibit the interstate transportation of goods produced with child labor); *Carter v. Carter Coal Co.*, 298 U.S. 238, 298, 308-10, 56 S. Ct. 855, 80 L. Ed. 1160 (1936) (holding that commerce power does not extend to the regulation of wages, hours, and working conditions of coal miners; defining commerce — consistent with the original understanding of the term — as "the equivalent of the phrase 'intercourse for the purposes of trade'")).

For example, in *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 55 S. Ct. 837, 79 L. Ed. 1570 (1935), a case well known to first year law students, the Court invalidated regulations fixing employee hours and wages in an intrastate business because the activity being regulated only related to interstate commerce "indirectly." The Supreme

Court characterized the distinction between "direct" and "indirect" effects on interstate commerce as "a fundamental one, essential to the maintenance of our constitutional system," for without it "there would be virtually no limit to the federal power and for all practical purposes we should have a completely centralized government." *Id.* at 548.

But, everything changed in 1937, beginning with the first of three significant New Deal cases. In *N.L.R.B. v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 57 S. Ct. 615, 81 L. Ed. 893 (1937), the Supreme Court, after recognizing the well known principle "that acts which directly burden or obstruct interstate or foreign commerce, or its free flow, are within the reach of the congressional power" [*see id.* at 31], held for the first time that Congress could also regulate purely intrastate activities that could be said to have a "substantial effect" on interstate commerce. "Although activities may be intrastate in character when separately considered, if they have such a close and substantial relation to interstate commerce that their control is essential or appropriate to protect that commerce from burdens and obstructions, Congress cannot be denied the power to exercise that control." *Id.* at 37. The question was now "the effect upon interstate commerce of the [intrastate activity] involved." *Id.* at 40 (emphasis added).

Four years later, in *United States v. Darby*, 312 U.S. 100, 61 S. Ct. 451, 85 L. Ed. 609 (1941), the Supreme Court overruled *Hammer v. Dagenhart*, supra. In upholding the wage and hour requirements in the Fair Labor Standards Act, and its suppression of substandard labor conditions, the Court reaffirmed that with respect to intrastate "transactions" and "activities" having a substantial effect on interstate commerce, Congress may regulate them without doing violence to the Constitution. *See id.* at 118-23.

And then came *Wickard v. Filburn*, 317 U.S. 111, 63 S. Ct. 82, 87 L. Ed. 122 (1942), which, until recently, was widely considered the most far-reaching expansion of Commerce Clause regulatory authority over intrastate activity. At issue in *Wickard* were amendments to the Agricultural Adjustment Act of 1938 that set acreage allotments for wheat farmers in an effort to control supply and avoid surpluses that could result in abnormally low wheat prices. The plaintiff in that case, Roscoe Filburn, owned a small farm on which he raised and harvested wheat, among other things. When he exceeded his allotment by 12 acres (which yielded 239 bushels of wheat), he was penalized under the statute. Although the intended disposition of the crop involved in the case was not "expressly stated," [*id.* at 114], the Supreme Court assumed and analyzed the issue as though the excess wheat was "not intended in any part for commerce but wholly for consumption on the farm." *See id.* at 118. Even though production of such wheat "may not be regarded as commerce" in the strictest sense of the word, [*see id.* at 125], consumption on the farm satisfied needs that would (theoretically, at least) be otherwise filled by another purchase or commercial transaction. *See id.* at 128 (explaining that homegrown wheat "supplies a need of the man who grew it which would otherwise be reflected by purchases in the open market [and] in this sense competes with wheat in commerce"). In holding that Congress had power under the Commerce Clause to regulate production intended for personal consumption, the Supreme Court stated:

> [E]ven if appellee's activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce and this irrespective of whether such effect is what might at some earlier time have been defined as "direct" or "indirect."
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> * * *
>
> That appellee's own contribution to the demand for wheat may be trivial by itself is not enough to remove him from the scope of federal regulation where, as here, his contribution, taken together with that of many others similarly situated, is far from trivial.

Id. at 125, 127-28. The latter statement is commonly known and described as the "aggregation principle." It allows Congress under the Commerce Clause to reach a "class of activities" that have a substantial impact on interstate commerce when those activities are aggregated with all similar and related activities — even though the activities within the class may be themselves trivial and insignificant. *See, e.g., Maryland v. Wirtz*, 392 U.S. 183, 192-93, 196 n.27, 88 S. Ct. 2017, 20 L. Ed. 2d 1020 (1968) (any claim that reviewing courts have the power to excise, as trivial, individual activity within a broader class of activities "has been put entirely to rest" as the "de minimis character of individual instances arising under [the] statute is of no consequence"). To illustrate this principle, as applied in *Wickard*, even though Filburn's 239 bushels were presumably for his own consumption and seed, and did not significantly impact interstate commerce, if every farmer in the country did the same thing, the aggregate impact on commerce would be cumulatively substantial.

Together, *Jones & Laughlin Steel*, *Darby*, and *Wickard* either "ushered in" a new era of Commerce Clause jurisprudence "that greatly expanded the previously defined authority of Congress under that Clause" [*Lopez*, *supra*, 514 U.S. at 556], or they merely "restored" the "broader view of the Commerce Clause announced by Chief Justice Marshall." *Perez*, *supra*, 402 U.S. at 151. Regardless of whether the cases represented a new era or simply a restoration of the old, it seemed that from that point forward congressional action under the Commerce Clause was to be given virtually insurmountable deference. *See* Kenneth Klukowski, *Citizen Gun Rights: Incorporating the Second Amendment Through the Privileges or Immunities Clause*, 39 N.M. L. Rev. 195, 232-33 (2009) (noting that in these New Deal cases "the Court read the Commerce Clause so broadly that it is a bold statement to say that the provision even nominally constrained federal action"). And, indeed, from the New Deal period through the next five decades, not a single federal legislative enactment was struck down as exceeding Congress' power under the Commerce Clause power — until *Lopez* in 1995.

In *United States v. Lopez* the Supreme Court considered the Constitutionality of the Gun Free School Zones Act of 1990, which criminalized the possession of a firearm in a school zone. In holding that the statute exceeded Congress' authority under the Commerce Clause, the Supreme Court began by recognizing the "first principles" behind the limitations on federal power as set forth in the Constitution. *See supra*, 514 U.S. at 552. Then, after detailing the history and transformation of Commerce Clause jurisprudence — from *Gibbons*, to *A.L.A. Schechter Poultry*, and up through *Wickard* — the Court observed that even in cases which had interpreted the Commerce Clause more expansively, every decision to date had recognized that the power granted by the Clause is necessarily "subject to outer limits" which, if not recognized and respected, could lead to federal action that would "effectually obliterate the distinction between what is national and what is local and create a completely centralized government." *See generally id.* at 553-57. Consistent with those limits, the *Lopez* Court stated "we have identified three broad categories of *activity* that Congress may regulate under its commerce power." *See id.* at 558 (emphasis added). The "substantially affects" category was the one at issue there, and in holding that the statute did not pass muster thereunder, the Supreme Court focused on four considerations: (i) the activity being regulated (guns near schools) was not economic in nature; (ii) the statute did not contain jurisdictionally limiting language; (iii) Congress did not make any formal findings concerning the effect of the regulated activity on commerce; and (iv) the connection between that activity and its effect on commerce was attenuated. *See generally id.* at 559-67.

As for the fourth consideration, the Court impliedly conceded the claims by the government and the dissent that: (1) gun-related violence is a serious national problem with substantial costs that are spread throughout the population; (2) such violence has adverse effects on classroom learning (which can result in decreased productivity) and discourages traveling into areas felt to be unsafe; all of which, in turn, (3) represents a substantial threat to interstate commerce. The *Lopez* majority made a point to "pause to consider the implications" of such arguments, however. *See id.* at 563-65. It found that if such theories were sufficient to justify regulation under the Commerce clause (even though their underlying logic and truth were not questioned), "it is difficult to perceive any limitation on federal power" and "we are hard pressed to posit any activity by an individual that Congress is without power to regulate." *See id.* at 564. To accept such arguments and uphold the statute, the majority concluded, would require the Court:

> . . . to pile inference upon inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States. Admittedly, some of our prior cases have taken long steps down that road, giving great deference to congressional action. The broad language in these opinions has suggested the possibility of additional expansion, but we decline here to proceed any further. To do so would require us to conclude that the Constitution's enumeration of powers does not presuppose something not enumerated, and that there never

> will be a distinction between what is truly national and what is truly local. This we are unwilling to do.

Id. at 567-68; *see also id.* at 578, 580 (explaining that it is the Court's duty to "recognize meaningful limits on the commerce power" and intervene if Congress "has tipped the scales too far" as federal balance "is too essential a part of our constitutional structure and plays too vital a role in securing freedom") (Kennedy, J., concurring).

The next significant Commerce Clause case to be decided by the Supreme Court was the 2000 case of *United States v. Morrison*, supra, 529 U.S. at 598, which involved a challenge to the Violence Against Women Act of 1994. The government argued in that case — similar to what it did in *Lopez* — that Congress could regulate gender-motivated violence based on a syllogistic theory that victims of such violence are deterred from traveling and engaging in interstate business or employment; they are thus less productive (and incur increased medical and other costs); all of which, in turn, substantially affects interstate commerce. *See id.* at 615. The Court began its analysis by recognizing the foundational principle that the power of the federal government is "defined and limited" and therefore: "Every law enacted by Congress must be based on one or more of its powers enumerated in the Constitution." *See id.* at 607. It emphasized that while the legal analysis of the Commerce Clause "has changed as our Nation has developed," which has resulted in Congress having "considerably greater latitude in regulating conduct and transactions under the Commerce Clause than our previous case law permitted," authority under the Clause "is not without effective bounds." *See id.* at 607-08. The Court then looked to the four "significant considerations" that were identified in *Lopez* and found that, "[w]ith these principles underlying our Commerce Clause jurisprudence as reference points, the proper resolution of the present cases is clear." *See id.* at 610-13. First, the statute at issue in *Morrison* did not regulate economic activity:

> Gender-motivated crimes of violence are not, in any sense of the phrase, economic activity. While we need not adopt a categorical rule against aggregating the effects of any noneconomic activity in order to decide these cases, thus far in our Nation's history our cases have upheld Commerce Clause regulation of intrastate activity only where that activity is economic in nature.

Id. at 613. Further, the statute did not contain jurisdictionally limiting language; and while it was supported, in contrast to *Lopez*, with numerous congressional findings regarding the personal, familial, and economic impact of gender-motivated violence, those findings were insufficient to sustain the legislation as they relied on the same "method of reasoning that we have already rejected as unworkable if we are to maintain the Constitution's enumeration of powers." *Id.* at 615. In other words, it would require the Court "to pile inference upon inference," and, in the process, run the risk of "completely obliterat[ing] the Constitution's distinction between national and local authority." *See id.*

In light of the circumscriptial rulings in *Lopez* and *Morrison*, many were surprised by the Supreme Court's subsequent decision in *Gonzales v. Raich*, 545 U.S. 1, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005), which was not only seen as a return to the more expansive Commerce Clause jurisprudence [*see, e.g.*, Matthew Farley, *Challenging Supremacy: Virginia's Response to the Patient Protection and Affordable Care Act*, 45 U. Rich. L. Rev. 37, 65 (2010)], but was, in fact, viewed by some as even going beyond and "displacing" *Wickard* as the most far-reaching of all Commerce Clause cases. *See* Douglas W. Kmiec, *Gonzales v. Raich: Wickard v. Filburn Displaced*, 2005 Cato Sup. Ct. Rev. 71 (2005).

At issue in *Raich* was whether Congress had authority under the Commerce and Necessary and Proper Clauses to prohibit, via the Controlled Substances Act, "the local cultivation and use of marijuana in compliance with California law." *See Raich, supra*, 545 U.S. at 5. The marijuana at issue, which was being used by two seriously ill women for medicinal purposes pursuant to state law, had been neither bought nor sold and never crossed state lines. It was, and is, illegal in most states, and does not have a legal free market in interstate commerce, the normal attribute of any economic analysis. Nevertheless, the Supreme Court began its analysis by stating: "Our case law firmly establishes Congress' power to regulate purely local activities that are part of an economic 'class of activities' that have a substantial effect on interstate commerce." *Id.* at 17. The Court found *Wickard* to be "striking" in similarity and "of particular relevance" to the analysis as that case "establishes that Congress can regulate purely intrastate activity that is not itself 'commercial,' in that it is not produced for sale, if it concludes that failure to regulate that class of activity would undercut regulation of the interstate market in that commodity." *Id.* at 17-18. The Court held that Congress had a "rational basis" for finding that leaving home-consumed marijuana outside of federal control would affect the price and market conditions for that commodity because, as was noted in *Wickard*, the "production of the commodity meant for home consumption, be it wheat or marijuana, has a substantial effect on supply and demand in the national market for that commodity." *See id.* at 19. Surprisingly, "[t]hat the market in *Raich* happened to be an illegal one did not affect the Court's analysis in the least." *Maxwell, supra*, 446 F.3d at 1214.

The Eleventh Circuit has indicated that the distinguishing feature between *Raich* and *Wickard* on the one hand, and *Morrison* and *Lopez* on the other, "was the comprehensiveness of the economic component of the regulation." *Maxwell, supra,* 446 F.3d at 1214. The statute in *Lopez*, for example, was a brief, single-subject criminal statute that did not regulate any economic activity. By contrast, the statute in *Raich* was a broader legislative scheme "at the opposite end of the regulatory spectrum." *Supra,* 545 U.S. at 24. It was "a lengthy and detailed statute creating a comprehensive framework for regulating the production, distribution, and possession of [controlled substances]," which were "activities" the Supreme Court determined to be "quintessentially economic" in nature. *See id.* at 24-25. The Court reached this conclusion by "quite broadly defin[ing] 'economics' as 'the production, distribution, and consumption of commodities.'" *See Maxwell, supra*, 446 F.3d at 1215 n.4 (quoting *Raich, supra*, 545 U.S. at 25-26, in turn quoting Webster's Third New International Dictionary 720 (1966)).[13]

(c) Application of the Foregoing to the Facts of this Case

Unsurprisingly, the plaintiffs rely heavily on *Lopez* and *Morrison* in framing their arguments, while the defendants, of course, look principally to *Wickard* and *Raich*. These cases (along with the others discussed above) all have something to add to the discussion. However, while they frame the analysis, and are important from a historical perspective, they do not by themselves resolve this case. That is because, as Congress' attorneys in the Congressional Research Service ("CRS") and Congressional Budget Office ("CBO") advised long before the Act was passed into law, the notion of Congress having the power under the Commerce Clause to directly impose an individual mandate to purchase health care insurance is "novel" and "unprecedented." *See* Jennifer Staman & Cynthia Brougher, Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, July 24, 2009, at 3, 6 ("whether Congress can use its Commerce Clause authority to require a person to buy a good or a service" raises a "novel issue" and "most challenging question") ("CRS Analysis"); Congressional Budget Office Memorandum, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance*, August 1994 ("A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action.") ("CBO Analysis"). Never before has Congress required that everyone buy a product from a private company (essentially for life) just for being alive and residing in the United States.[14]

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[13] In objecting to the majority's use of this "broadest possible" definition, Justice Thomas argued in dissent that "economics" is not defined as broadly in other dictionaries, and "the majority does not explain why it selects a remarkably expansive 40-year-old definition." *Raich, supra*, 545 U.S. at 69 and n.7 (Thomas, J., dissenting).

As I explained in my earlier order, the fact that legislation is unprecedented does not by itself render it unconstitutional. To the contrary, all federal legislation carries with it a "presumption of constitutionality." *Morrison, supra*, 529 U.S. at 607. However, the presumption is arguably weakened, and an "absence of power" might reasonably be inferred where — as here — "earlier Congresses avoided use of this highly attractive power." *Printz v. United States*, 521 U.S. 898, 905, 908, 117 S. Ct. 2365, 138 L. Ed. 2d 914 (1997); *id.* at 907-08 ("the utter lack of statutes imposing obligations [like the one at issue in that case] (notwithstanding the attractiveness of that course to Congress), suggests an assumed *absence* of such power") (emphasis in original); *id.* at 918 ("almost two centuries of apparent congressional avoidance of the practice [at issue] tends to negate the existence of the congressional power asserted here").[15] The mere fact that the defendants have tried to analogize the individual mandate to things like jury service, participation in the census, eminent domain proceedings, forced exchange of gold bullion for paper currency under the *Gold Clause Cases*, and required service in a "posse" under the Judiciary Act of 1789 (all of which are obviously distinguishable) only underscores and highlights its unprecedented nature.

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[14] The individual mandate differs from the regulations in *Wickard* and *Raich*, for example, in that the individuals being regulated in those cases were engaged in an activity (regardless of whether it could readily be deemed interstate commerce in itself) and each had the choice to discontinue that activity and avoid penalty. *See, e.g., Wickard v. Filburn*, 317 U.S. 111, 130, 63 S. Ct. 82, 87 L. Ed. 122 (1942) (noting Congress "gave the farmer a choice" of several options under the statute). Here, people have no choice but to buy insurance or be penalized. And their freedom is actually more restricted as they do not even have a choice as to the minimum level or type of insurance to buy because Congress established the floor. A single twenty-year old man or woman who only needs and wants major medical or catastrophic coverage, for example, is precluded from buying such a policy under the Act.

However, unprecedented or not, I will assume that the individual mandate can be Constitutional under the Commerce Clause and will analyze it accordingly. This analysis requires the resolution of two essential questions.

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[15] Indeed, as the plaintiffs have persuasively noted, not even in the context of insurance under the National Flood Insurance Program did Congress mandate that all homeowners buy flood insurance directly from a private company. *See* Pl. Opp. at 26-27.

(i) Is Activity Required Under the Commerce Clause?

The threshold question that must be addressed is whether activity is required before Congress can exercise its power under the Commerce Clause. As previously discussed, Commerce Clause jurisprudence has "'taken some turns,'" [*see Lopez, supra*, 514 U.S. at 579 (Kennedy, J., concurring)], and contracted and expanded (and contracted and expanded again) during our nation's development. But, in every one of the cases — in both the contractive and expansive — there has always been clear and inarguable *activity*, from exerting control over and using navigable waters (*Gibbons*) to growing or consuming marijuana (*Raich*).[16] In all the cases discussed above, the Supreme Court was called upon to decide different issues (e.g., whether commerce encompassed navigation; whether it included manufacture and agriculture or was limited to trade or exchange of goods; whether the activity at issue was interstate or intrastate and had a direct or indirect effect on commerce; whether that effect was substantial; whether the activity was economic or noneconomic; and whether it was part of a single-subject statute or a necessary and essential component of a broader comprehensive scheme), but it has never been called upon to consider if "activity" is required. On this point at least, the district courts that have reached opposite conclusions on the individual mandate agree. *Compare Thomas More Law Center, supra*, 720 F. Supp. 2d at 893 (noting that the Supreme Court "has never needed to address the activity/inactivity distinction advanced by plaintiffs because in every Commerce Clause case presented thus far, there has been some sort of activity"; then proceeding to uphold the individual mandate), *with Virginia, supra*, 728 F. Supp. 2d at 781 (noting that "every application of Commerce Clause power found to be constitutionally sound by the Supreme Court involved some form of action, transaction, or deed placed in motion by an individual or legal entity"; then proceeding to strike down the individual mandate).

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[16] The defendants cite to *Raich* for the proposition that Congress may reach "even wholly intrastate, non-commercial matters when it concludes that the failure to do so would undercut a larger program regulating interstate commerce." *See* Def. Mem. at 13. By paraphrasing *Raich* here rather than quoting from the decision the defendants have attempted to obscure the importance of "activity," for the cited portion, and Justice Scalia's concurrence (on which the defendants also rely), do not talk at all of "matters" — either commercial or not. They only mention (and often) "activities."

The defendants contend, however, that despite the inarguable presence of activity in every Supreme Court case to date, activity is not required under the Commerce Clause. *See* Def. Mem. at 31 (maintaining that "there is no 'activity' clause in the constitution"). In fact, they go so far as to suggest that to impose such a requirement would be bold and radical. According to the defendants, because the Supreme Court has never identified a distinction between activity and inactivity as a limitation on Congress' commerce power, to hold otherwise would "break new legal ground" and be "novel" and "unprecedented." *See* Def. Opp. at 1, 2, 16. First, it is interesting that the defendants — apparently believing the best defense is a good offense — would use the words "novel" and "unprecedented" since, as previously noted, those are the *exact* same words that the CRS and CBO used to describe the individual mandate before it became law. Furthermore, there is a simple and rather obvious reason why the Supreme Court has never distinguished between activity and inactivity before: it has not been called upon to consider the issue because, until now, Congress had never attempted to exercise its Commerce Clause power in such a way before. *See* CBO Analysis (advising Congress during the previous health care reform efforts in 1994 that "[t]he government has never required people to buy any good or service as a condition of lawful residence in the United States."). In every Supreme Court case decided thus far, Congress was not seeking to regulate under its commerce power something that could even arguably be said to be "passive inactivity."[17]

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[17] I note that in *Gibbons v. Ogden*, where Chief Justice Marshall "described the Federal Commerce power with a breadth never yet exceeded" [*Wickard*, *supra*, 317 U.S. at 111], commerce was defined as "intercourse." Even that word would seem to carry with it an implicit presumption of at least some sort of preexisting dealing between people or entities. *See* 1 Samuel Johnson, *A Dictionary of the English Language* (4th ed. 1773) (defining "intercourse" as "Commerce; exchange" and "Communication"). Furthermore, as one of the amici notes in their brief, the word "regulate" in the Commerce Clause itself would also appear to presuppose action upon some object or activity that is already extant (*see* doc. 121 at 4 n.1, citing Samuel Johnson's dictionary defining "regulate" as "to adjust

It would be a radical departure from existing case law to hold that Congress can regulate inactivity under the Commerce Clause. If it has the power to compel an otherwise passive individual into a commercial transaction with a third party merely by asserting — as was done in the Act — that compelling the actual transaction is *itself* "commercial and economic in nature, and substantially affects interstate commerce" [*see* Act § 1501(a)(1)], it is not hyperbolizing to suggest that Congress could do almost anything it wanted. It is difficult to imagine that a nation which began, at least in part, as the result of opposition to a British mandate giving the East India Company a monopoly and imposing a nominal tax on all tea sold in America would have set out to create a government with the power to force people to buy tea in the first place. If Congress can penalize a passive individual for failing to engage in commerce, the enumeration of powers in the Constitution would have been in vain for it would be "difficult to perceive any limitation on federal power" [*Lopez, supra*, 514 U.S. at 564], and we would have a Constitution in name only. Surely this is not what the Founding Fathers could have intended. *See id.* at 592 (quoting Hamilton at the New York Convention that there would be just cause to reject the Constitution if it would allow the federal government to "penetrate the recesses of domestic life, and control, in all respects, the private conduct of individuals")

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by rule or method" or "to direct"). Thus, a regulator "comes to an existing phenomenon and orders it." *Id.*

(Thomas, J., concurring). In *Lopez*, the Supreme Court struck down the Gun Free School Zones Act of 1990 after stating that, if the statute were to be upheld, "we are *hard pressed* to posit any *activity* by an individual that Congress is without power to regulate." *See id.* at 564. (emphasis added). If some type of already-existing activity or undertaking were not considered to be a prerequisite to the exercise of commerce power, we would go beyond the concern articulated in *Lopez* for it would be virtually *impossible* to posit *anything* that Congress would be without power to regulate.

As previously noted, the Supreme Court has summarized and defined the current state of the law under the Commerce Clause, and it has uniformly and consistently declared that it applies to "three broad categories of *activity*." *Lopez, supra*, 514 U.S. at 558 (emphasis added); accord *Morrison, supra*, 529 U.S. at 608. It has further described the third category as "the power to regulate those *activities* having a substantial relation to interstate commerce." *Lopez, supra*, 514 U.S. at 558-59 (emphasis added); *accord Morrison, supra*, 529 U.S. at 609; *see also Raich, supra*, 545 U.S. at 17; *Perez*, 402 U.S. at 150; *Wickard, supra*, 317 U.S. at 124; *Darby, supra*, 312 U.S. at 119-20; *Jones & Laughlin Steel, supra*, 301 U.S. at 37. Without doubt, existing case law thus extends only to those "activities" that have a substantial relationship to, or substantially affect, interstate commerce. I am required to interpret this law as the Supreme Court presently defines it. Only the Supreme Court can redefine it or expand it further — a point implicitly made by one of the defendants' own cited authorities. *See* Stern, *supra*, at 1363 (stating that the Supreme Court had at one point in time only talked about "movement" of goods across state lines under the Commerce Clause because it was necessary to decide those earlier cases and there had "been no need for a broader definition" of commerce; going on to opine that "it would seem timely that the *Supreme Court*" expand the definition, as "the time has now arrived for the [*Supreme*] *Court* to cut loose from the 'old' approach and to select the 'new' one") (emphasis added).

Having found that "activity" is an indispensable part the Commerce Clause analysis (at least as currently understood, defined, and applied in Supreme Court case law), the Constitutionality of the individual mandate will turn on whether the failure to buy health insurance is "activity."

(ii) Is the Failure to Purchase Health Insurance "Activity"?

Preliminarily, based solely on a plain reading of the Act itself (and a common sense interpretation of the word "activity" and its absence), I must agree with the plaintiffs' contention that the individual mandate regulates inactivity. Section 1501 states in relevant part: "If an applicable individual fails to [buy health insurance], there is hereby imposed a penalty." By its very own terms, therefore, the statute applies to a person who does not buy the government-approved insurance; that is, a person who "fails" to act pursuant to the congressional dictate. In fact, prior to final passage of the Act, CRS attorneys advised Congress that it was "unclear" if the individual mandate had "solid constitutional foundation" specifically because:

> One could argue that while regulation of the health insurance industry or the health care system could be considered economic activity, regulating a choice to purchase health insurance is not. It may also be questioned whether a requirement to purchase health insurance is really a regulation of an economic activity or enterprise, if individuals who would be required to purchase health insurance are not, but for this regulation, a part of the health insurance market. In general, Congress has used its authority under the Commerce Clause to regulate individuals, employers, and others who voluntarily take part in some type of economic activity. While in *Wickard* and *Raich*, the individuals were participating in their own home activities (i.e., producing wheat for home consumption and cultivating marijuana for personal use), they were acting of their own volition, and this activity was determined to be economic in nature and affected interstate commerce. *However, [the individual mandate] could be imposed on some individuals who engage in virtually no economic activity whatsoever*. This is a novel issue: whether . . . this type of required participation can be considered economic activity.

CRS Analysis, *supra*, at 3, 6 (emphasis added).

The defendants insist that the uninsured are active. In fact, they even go so far as to make the claim — which the plaintiffs call "absurd" — that going without health insurance constitutes "economic activity to an even greater extent than the plaintiffs in *Wickard* or *Raich*." *See* Def. Mem. at 29. They offer two (somewhat overlapping) arguments why the appearance of inactivity here is just an "illusion."

(iii) The Purported "Uniqueness" of the Health Care Market

The defendants contend that there are three unique elements of the health care market which, when viewed cumulatively and in combination, belie the claim that the uninsured are inactive.[18] First, as living and breathing human beings who are always susceptible to sudden and unpredictable illness and injury, no one can "opt out" of the health care market. Second, if and when health services are sought, hospitals are required by law to provide care, regardless of inability to pay. And third, if the costs incurred cannot be paid (which they frequently cannot, given the high cost of medical care), they are passed along (cost-shifted) to third parties, which has economic implications for everyone. Congress found that the uninsured received approximately $43 billion in "uncompensated care" in 2008 alone. These three things, according to the defendants and various health care industry experts and scholars on whom they rely, are "replicated in no other market" and defeat the argument that uninsured individuals are inactive.[19]

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[18] During oral argument, the plaintiffs opposed defining the relevant market broadly as one for health *care*, insisting that the only relevant market for purposes of analyzing the individual mandate is the more specific health *insurance* market. I agree that the plaintiffs' position is the more precise and accurate. Every market can be broadly defined in a way that encompasses the specific characteristics one seeks to reach or include. Nonetheless, I will consider and examine the defendants' claim that the individual mandate is justifiable because the much broader "health care market" is purportedly unique.

First, it is not at all clear whether or why the three allegedly unique factors of the health care market are Constitutionally significant. What if only one of the three factors identified by the defendants is present? After all, there are lots of markets — especially if defined broadly enough — that people cannot "opt out" of. For example, everyone must participate in the food market. Instead of attempting to control wheat supply by regulating the acreage and amount of wheat a farmer could grow as in *Wickard*, under this logic, Congress could more directly raise too low wheat prices merely by increasing demand through mandating that every adult purchase and consume wheat bread daily, rationalized on the grounds that because everyone must participate in the market for food, non-consumers of wheat bread adversely affect prices in the wheat market. Or, as was discussed during oral argument, Congress could require that people buy and consume broccoli at regular intervals, not only because the required purchases will positively impact interstate commerce, but also because people who eat healthier tend to be healthier, and are thus more productive and put less of a strain on the health care system. Similarly, because virtually no one can be divorced from the transportation market, Congress could require that everyone above a certain income threshold buy a General Motors automobile — now partially government-owned — because those who do not buy GM cars (or those who buy foreign cars) are adversely impacting commerce and a taxpayer-subsidized business.

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[19] For example, in their briefs and during oral argument, the defendants cited to and relied on the *amicus* brief filed by an impressive list of nearly forty economic scholars, who have urged that these "three observations . . . do not exist in other contexts" and establish that the uninsured are not inactive and passive bystanders, but rather they "participate in the market for medical services and necessarily affect the market for health insurance" (doc. 125 at 6-13).

I pause here to emphasize that the foregoing is not an irrelevant and fanciful parade of horribles." Rather, these are some of the serious concerns implicated by the individual mandate that are being discussed and debated by legal scholars. For example, in the course of *defending* the Constitutionality of the individual mandate, and responding to the same concerns identified above, often-cited law professor and dean of the University of California Irvine School of Law Erwin Chemerinsky has opined that although "what people choose to eat well might be regarded as a personal liberty" (and thus unregulable), "Congress could use its commerce power to require people to buy cars." *See* ReasonTV, *Wheat, Weed, and Obamacare: How the Commerce Clause Made Congress All-Powerful*, August 25, 2010, available at: http://reason.tv/video/show/wheat-weed-and-obama care-how-t. When I mentioned this to the defendants' attorney at oral argument, he allowed for the possibility that "maybe Dean Chemerinsky is right." *See* Tr. at 69. Therefore, the potential for this assertion of power has received at least some theoretical consideration and has not been ruled out as Constitutionally implausible.[20]

Or what if two of the purported "unique" factors — inevitable participation coupled with cost-shifting — are present? For example, virtually no one can opt out of the housing market (broadly defined) and a majority of people will at some point buy a home. The vast majority of those homes will be financed with a mortgage, a large number of which (particularly in difficult economic times, as we have seen most recently) will go into default, thereby cost-shifting billions of dollars to third parties and the federal government. Should Congress thus have power under the Commerce Clause to preemptively regulate and require individuals above a certain income level to purchase a home financed with a mortgage (and secured with mortgage guaranty insurance) in order to add stability to the housing and financial markets (and to guard against the possibility of future cost-shifting because of a defaulted mortgage), on the theory that most everyone is currently, or inevitably one day will be, active in the housing market?

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[20] There is perhaps a general assumption that it is "ridiculous" to believe that Congress *would* do such a thing, even though it *could*. However, before *Wickard* was decided, it is likely that most people (including legal scholars and judges) would have thought it equally "ridiculous" to believe that Congress would one day seek (and be permitted) to regulate (as interstate commerce) the amount of wheat that a farmer grew on a small private farm for his personal consumption. In any event, even if such an assumption is well-founded, "the limitation of congressional authority is not solely a matter of legislative grace." *See Morrison*, *supra*, 529 U.S. at 616; *see also id.* at 616 n.7 (stating that legislative power is not limited only by "the Legislature's self-restraint"); *cf. United States v. Stevens*, — U.S. —, 130 S. Ct. 1577, 1591, 176 L. Ed. 2d 435 (2010) ("[T]he [Constitution] protects against the Government; it does not leave us at the mercy of noblesse oblige. We would not uphold an unconstitutional statute merely because the Government promised to use it responsibly.").

In alluding to these same general concerns, another court has observed that requiring advance purchase of health insurance based on a future contingency that will substantially affect commerce could also "apply to transportation, housing, or nutritional decisions. This broad definition of the economic activity subject to congressional regulation lacks logical limitation and is unsupported by Commerce Clause jurisprudence." *See Virginia, supra*, 728 F. Supp. 2d at 781. That the defendants' argument is "unsupported by Commerce Clause jurisprudence" can perhaps best be seen by looking to *Lopez*. Although that case is distinct from this one in some notable ways (e.g., it involved a brief, single-subject criminal statute that did not contain detailed legislative findings), in the context of the defendants' "health care is unique" argument, it is quite similar.

In *Lopez*, the majority was concerned that using the Commerce Clause to regulate things such as possession of guns in school zones would "obliterate" the distinction between what is national and what is local and effectively create a centralized government that could potentially permit Congress to begin regulating "any and all aspects" of our lives, including marriage, divorce, child custody, and education. The dissent insisted that this concern was unfounded because the statute at issue was "aimed at curbing a *particularly acute* threat" of violence in schools that had "*singularly* disruptive potential." *Supra*, 514 U.S. at 624 (Breyer, J., dissenting). Relying on "empirical evidence . . . documented by scholars," the dissent highlighted the link between education and the national economy and "the *special way* in which guns and education are incompatible." *See id.* The impact on commerce, it was urged, derived from the unchallenged fact that "violent crime in school zones has brought about a decline in the quality of education" which, in turn, has "an adverse impact on interstate commerce." *See id.* at 623 (citation and quotation marks omitted). This was "the *rare* case, then, that a statute strikes at conduct that (when considered in the abstract) seems so removed from commerce, but which (practically speaking) has so significant an impact upon commerce." *Id.* (all emphasis added).

Two things become apparent after reading these arguments attempting to justify extending Commerce Clause power to the legislation in that case, and the majority opinion (which is the controlling precedent) rejecting those same arguments. First, the contention that Commerce Clause power should be upheld merely because the government and its experts or scholars claim that it is being exercised to address a "particularly acute" problem that is "singular[ ]," "special," and "rare"—that is to say "unique"—will not by itself win the day. Uniqueness is not an adequate limiting principle as every market problem is, at some level and in some respects, unique. If Congress asserts power that exceeds its enumerated powers, then it is unconstitutional, regardless of the purported uniqueness of the context in which it is being asserted.

Second, and perhaps more significantly, under *Lopez* the causal link between what is being regulated and its effect on interstate commerce cannot be attenuated and require a court "to pile inference upon inference," which is, in my view, exactly what would be required to uphold the individual mandate. For example, in contrast to individuals who grow and consume marijuana or wheat (even in extremely small amounts), the mere status of being without health insurance, in and of itself, has absolutely no impact whatsoever on interstate commerce (not "slight," "trivial," or "indirect," but *no impact whatsoever*) — at least not any more so than the status of being without any particular good or service. If impact on interstate commerce were to be expressed and calculated mathematically, the status of being uninsured would necessarily be represented by zero. Of course, any other figure multiplied by zero is also zero. Consequently, the impact must be zero, and of no effect on interstate commerce. The uninsured can only be said to have a substantial effect on interstate commerce in the manner as described by the defendants: (i) if they get sick or injured; (ii) if they are still uninsured at that specific point in time; (iii) if they seek medical care for that sickness or injury; (iv) if they are unable to pay for the medical care received; and (v) if they are unable or unwilling to make payment arrangements directly with the health care provider, or with assistance of family, friends, and charitable groups, and the costs are thereafter shifted to others. In my view, this is the sort of piling "inference upon inference" rejected in *Lopez, supra*, 514 U.S. at 567, and subsequently described in *Morrison* as "unworkable if we are to maintain the Constitution's enumeration of powers." *Supra*, 529 U.S. at 615.[21]

I do not mean to suggest that these inferences are illogical or unreasonable to draw. As did the majority in *Lopez* and *Morrison*, I do not dispute or question their underlying existence. Indeed, while $43 billion in uncompensated care from 2008 was only 2% of national health care expenditures for that year, it is clearly a large amount of money; and it demonstrates that a number of the uninsured are taking the five sequential steps. And when they do, Congress plainly has the power to regulate them at that time (or even at the time that they initially seek medical care), a fact with which the plaintiffs agree. But, to cast the net wide enough to reach everyone *in the present*, with the expectation that they will (or could) take those steps *in the future*, goes beyond the existing "outer limits" of the Commerce Clause and would, I believe, require inferential leaps of the sort rejected in *Lopez*. To the extent the defendants have suggested it is "empty formalism" [Def. Mem. at 16] to hold that the uninsured can be regulated at the time they seek or fail to pay for medical care (but not before) the Supreme Court has explained:

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[21] I suppose it is also possible to contend that being uninsured impacts the economy because (regardless of whether the uninsured receive care that is cost-shifted to others) people without insurance tend to be less healthy and thus less productive. This seems to be the basis of one of Congress' findings. *See* Act § 1501(a)(2)(E) (finding that the national economy "loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured"). However, such a claim would be similar to the argument that was rejected in *Morrison*, i.e., that victims of gender-motivated violence also tend to be less productive.

> Much of the Constitution is concerned with setting forth the form of our government, and the courts have traditionally invalidated measures deviating from that form. The result may appear "formalistic" in a given case to partisans of the measure at issue, because such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day . . . . [A] judiciary that licensed extra-constitutional government with each issue of comparable gravity would, in the long run, be far worse [than the crisis itself].

New York, supra, 505 U.S. at 187.

In short, the defendants' argument that people without health insurance are actively engaged in interstate commerce based on the purported "unique" features of the much broader health care market is neither factually convincing nor legally supportable.[22]

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[22] The defendants also suggest that the uninsured are "active" in the health insurance market — and therefore can be regulated and forced to buy insurance — because a large

(iv) The "Economic Decision" to Forego Health Insurance

The defendants next contend that the uninsured have made the calculated decision to engage in market timing and try to finance their future medical needs out-of-pocket rather than through insurance, and that this "economic decision" is tantamount to activity. The plaintiffs respond by suggesting that it is "a remarkable exaggeration of [the] rational aspects of human nature" to claim that the uninsured (as a rule) make structured and calculated decisions to forego insurance and engage in market timing, as opposed to simply not having it. *See* Tr. at 16 ("All we know is some people do not have insurance and some people do"). The plaintiffs describe the defendants' argument on this point "Orwellian," because they seek "to redefine the inactivity of not having healthcare insurance as an affirmative economic activity of 'deciding' not to buy insurance, or deciding *now* how to pay (or not to pay) for potential *future* economic activity in the form of obtaining medical services." *See* Pl. Opp. at 10 (emphasis in original). This "economic decision" argument has been accepted by two district courts, *Liberty Univ., Inc., supra,* 2010 WL 4860299, at *15; *Thomas More Law Center, supra,* 720 F. Supp. 2d at 893-94. For example, in *Liberty University,* the

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percentage of them have had insurance within the past year. The defendants have provided no authority for the suggestion that once someone is in the health insurance market at a particular point in time, they are forever in that market, always subject to regulation, and not ever permitted to leave.

District Court for the Western District of Virginia stated that "by choosing to forego insurance, Plaintiffs are making an economic decision to try to pay for health care services later, out of pocket, rather than now, through the purchase of insurance," and concluded that these decisions constitute economic activity "[b]ecause of the nature of supply and demand, Plaintiffs choices directly affect the price of insurance in the market, which Congress set out in the Act to control." *See* 2010 WL 4860299, at *15.

The problem with this legal rationale, however, is it would essentially have unlimited application. There is quite literally *no* decision that, in the natural course of events, does not have an economic impact of some sort. The decisions of whether and when (or not) to buy a house, a car, a television, a dinner, or even a morning cup of coffee also have a financial impact that — when aggregated with similar economic decisions — affect the price of that particular product or service and have a substantial effect on interstate commerce. To be sure, it is not difficult to identify an economic decision that has a cumulatively substantial effect on interstate commerce; rather, the difficult task is to find a decision that does not.[23]

Some of our wisest jurists have pointed out the threat that lies in an over-expansive Commerce

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[23] As was discussed at the hearing, even personal decisions about whether to marry, whom to marry, or whether to have children could also be characterized as "economic decisions."

Clause construction. The words that Judge Learned Hand wrote in 1935 are even truer today:

> In an industrial society bound together by means of transport and communication as rapid and certain as ours, it is idle to seek for any transaction, however apparently isolated, which may not have an effect elsewhere; such a society is an elastic medium which transmits all tremors throughout its territory; the only question is of their size.

United States v. A.L.A. Schechter Poultry Corp., 76 F.2d 617, 624 (2d Cir. 1935), *aff'd in part and rev'd in part, supra*, 295 U.S. at 554 (noting in an elastic society like ours everything affects commerce in the sense that "[m]otion at the outer rim is communicated perceptibly, though minutely, to recording instruments at the center;" but to hold that everything may thus be regulated under the Commerce Clause "will be an end to our federal system") (Cardozo, J., concurring). As the Supreme Court emphasized in *Morrison, supra*: "'In a sense any conduct in this interdependent world of ours has an ultimate commercial origin or consequence, but we have not yet said the commerce power may reach so far.'" 529 U.S. at 611 (quoting *Lopez, supra*, 514 U.S. at 580 (Kennedy, J., concurring)); *accord Patton, supra*, 451 F.3d at 628 (explaining that everything could be said to affect interstate commerce "in the same sense in which a butterfly flapping its wings in China might bring about a change of weather in New York," but if all things affecting interstate commerce were held to be within Congress' regulatory power, "the Constitution's enumeration of powers would have been in vain").

Attempting to deflect this rather common sense rebuttal to their argument, the defendants emphasized during oral argument that it is not just the "economic decision" itself that renders the failure to buy insurance activity; rather, it is that decision coupled with the fact that the uninsured are guaranteed access to medical care in hospital emergency rooms as a "backstop," the use of which can and does shift costs onto third parties. The defendants thus refer to the failure to buy health insurance as a "financing decision." However, this is essentially true of any and all forms of insurance. It could just as easily be said that people without burial, life, supplemental income, credit, mortgage guaranty, business interruption, or disability insurance have made the exact same or similar economic and financing decisions based on their expectation that they will not incur a particular risk at a particular point in time; or that if they do, it is more beneficial for them to self-insure and try to meet their obligations out-of-pocket, but always with the benefit of "backstops" provided by law, including bankruptcy protection and other government-funded financial assistance and services. *See, e.g.*, Katie Zezima, *Indigent Burials Are On the Rise*, New York Times, Oct. 11, 2009, at A23 (reporting the number of burials of those who die with insufficient assets are increasing across the country, up 50% in Oregon, and that funeral expenses are frequently borne by governmental entities; noting that Illinois alone budgets $12 million for these expenses). The "economic decision" to forego virtually any and all types of insurance can (and cumulatively do) similarly result in significant cost-shifting to third parties.[24]

The important distinction is that "economic decisions" are a much broader and far-reaching category than are "activities that substantially affect interstate commerce." While the latter necessarily encompasses the first, the reverse is not true. "Economic" cannot be equated to "commerce." And "decisions" cannot be equated to "activities." Every person throughout the course of his or her life makes hundreds or even thousands of life decisions that involve the same general sort of thought process that the defendants maintain is "economic activity." There will be no stopping point if that should be deemed the equivalent of activity for Commerce Clause purposes.[25]

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[24] To the extent that people dying without burial insurance is by itself not as severe a problem as people without health insurance — and I readily acknowledge it is not — that is merely a difference in degree, not in kind. The fact that people without health insurance pose a more serious problem than people without burial insurance may give Congress more of a *reason* to act; but it does not give it more Constitutional *authority* to do so. *See United States v. A.L.A. Schechter Poultry Corp.*, 76 F.2d 617, 624 (2d Cir. 1935) (noting that "emergency does not create the power [of Congress to act], but it may furnish the occasion for the exercise of the power conferred by the Constitution"), *aff'd in part and rev'd in part*, 295 U.S. 495, 55 S. Ct. 837, 79 L. Ed. 1570 (1935).

[25] For example, if the decision to forego insurance qualifies as activity, then presumably the decision to not use that insurance once it has been obtained is also activity. The government acknowledged during oral argument in *Virginia v. Sebelius* that although people are required to buy health

The Commerce Clause originally applied to the trade and exchange of goods as it sought to eliminate trade barriers by and between the states. Over the years, the Clause's reach has been expanded from covering actual interstate commerce (and its channels and instrumentalities) to intrastate activities that substantially affect interstate commerce. It has even been applied to activities that involve the mere consumption of a product (even if there is no legal commercial interstate market for that product). To now hold that Congress may regulate the so-called "economic decision" to *not* purchase a product or service in anticipation of *future* consumption is a "bridge too far." It is without logical limitation and far exceeds the existing legal boundaries established by Supreme Court precedent.

Because I find both the "uniqueness" and "economic decision" arguments unpersuasive, I conclude that the individual mandate seeks to

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insurance under the Act, they are not yet required to use it. *See* Transcript of Oral Argument on Defendants' Motion to Dismiss, July 1, 2010, at 26 ("the statute doesn't require anybody to [actually] get medical services"); *see also id.* at 30 ("Congress isn't saying go see a doctor, or you have to go. What Congress is saying is you have to purchase health insurance."). But what happens if the newly-insured (as a class) do not seek preventive medical care? Because Congress found in the Act that the economy loses money each year "because of the poorer health and shorter lifespan of the uninsured" [*see supra* note 19], it would seem only logical under the defendants' rationale that Congress may also regulate the "economic decisions" not to go to the doctor for regular check-ups and screenings to improve health and longevity, which, in turn, is intended and expected to increase economic productivity.

regulate economic inactivity, which is the very opposite of economic activity. And because activity is required under the Commerce Clause, the individual mandate exceeds Congress' commerce power, as it is understood, defined, and applied in the existing Supreme Court case law.

(2) The Necessary and Proper Clause

The defendants contend that the individual mandate is "also a valid exercise of Congress's authority if the provision is analyzed under the Necessary and Proper Clause." *See* Def. Mem. at 23. This argument has been appropriately called "the last, best hope of those who defend ultra vires congressional action." *See Printz, supra*, 521 U.S. at 923. Oversimplified, the defendants' argument on this point can be reduced to the following: (i) the Act bans insurers from denying health coverage (guaranteed issue), or charging higher premiums (community rating), to individuals with pre-existing medical conditions (which increases the insurers' costs); (ii) as a result of these bans, individuals will be incentivized to delay obtaining insurance as they are now guaranteed coverage if they get sick or injured (which decreases the insurers' revenues); and (iii) as a result of the foregoing, there will be fewer healthy people in the insured pool (which will raise the premiums and costs for everyone). Consequently, it is necessary to require that everyone "get in the pool" so as to protect the private health insurance market from inevitable collapse.

At the outset, I note that in *United States v. Comstock*, — U.S. —, 130 S. Ct. 1949, 176 L. Ed. 2d 878 (2010), the Supreme Court's most recent discussion and application of the Necessary and Proper Clause, the Court identified and looked to five "considerations" that informed its decision about whether the legislation a was sustainable: (1) the breadth of the Necessary and Proper Clause; (2) the history of federal involvement in the relevant arena, and the modest addition to that arena; (3) the sound reasons for the legislation in light of the government's interest; (4) the statute's accommodation of state interests; and (5) its narrow scope. It is not entirely clear if this constitutes a "five-factor test," as Justice Thomas urged in dissent, *see id.* at 1974, or whether the "considerations" were merely factors that the majority believed relevant to deciding that particular case. To the extent that they constitute a "test," the individual mandate clearly gets a failing score on at least two (and possibly a couple more) of the five elements. A statute mandating that everyone purchase a product from a private company or be penalized (merely by virtue of being alive and a lawful citizen) is not a "modest" addition to federal involvement in the national health care market, nor is it "narrow [in] scope." I will assume, however, that the *Comstock* "considerations" were just that, and that they did not bring about any fundamental change in the Court's long established Necessary and Proper Clause analysis.

The Necessary and Proper Clause provides that Congress shall have the power:

> To make all Laws which shall be *necessary and proper for carrying into Execution the foregoing Powers*, and all other Powers vested by this

> Constitution in the Government of the United States, or in any Department or Officer thereof.

U.S. Const. art. I, § 8, cl. 18 (emphasis added). The Supreme Court has repeatedly held, and the emphasized text makes clear, that the Clause is not an independent source of federal power; rather, it is simply "a caveat that the Congress possesses all the means necessary to carry out the specifically granted 'foregoing' powers of [section] 8 'and all other Powers vested by this Constitution.' [It] is 'but merely a declaration, for the removal of all uncertainty, that the means of carrying into execution those (powers) otherwise granted are included in the grant.'" *Kinsella v. United States ex rel. Singleton*, 361 U.S. 234, 247, 80 S. Ct. 297, 4 L. Ed. 2d 268 (1960); *see also Raich, supra*, 545 U.S. at 39 (Scalia, J., concurring in judgment) (stating that, while the Clause "empowers Congress to enact laws . . . that are not within its authority to enact in isolation," those laws must be "in effectuation of [Congress'] enumerated powers"); *Kansas v. Colorado*, 206 U.S. 46, 88, 27 S. Ct. 655, 51 L. Ed. 956 (1907) (stating that the Necessary and Proper Clause "is not the delegation of a new and independent power, but simply provision for making effective the powers theretofore mentioned").

Hamilton wrote the following in response to the concern voiced by some that the Necessary and Proper Clause — and the Supremacy Clause as well — could be used to expand federal power and destroy liberties:

> These two clauses have been the source of much virulent invective and petulant declamation

> against the proposed Constitution. They have been held up to the people in all the exaggerated colors of misrepresentation as the pernicious engines by which their local governments were to be destroyed and their liberties exterminated; as the hideous monster whose devouring jaws would spare neither sex nor age, nor high nor low, nor sacred nor profane; and yet, strange as it may appear, after all this clamor, to those who may not have happened to contemplate them in the same light, it may be affirmed with perfect confidence, that the constitutional operation of the intended government would be precisely the same, if these clauses were entirely obliterated, as if they were repeated in every article. They are only declaratory of a truth, which would have resulted by necessary and unavoidable implication from the very act of constituting a federal government, and vesting it with certain specific powers.

The Federalist No. 33, at 204-05. To the extent there was anything to fear in the Constitution, Hamilton explained, it must be found in the specific powers that were enumerated and not in the Necessary and Proper Clause, for though the latter "may be chargeable with tautology or redundancy, [it] is at least perfectly harmless." *See id.* at 206. Madison concurred with this view. *See The Federalist* No. 44, at 302 (explaining that the Clause is entirely redundant for if it had been omitted, "there can be no doubt" that the same power and authority "would have resulted to the government, by unavoidable implication"). If these advocates for ratification had any inkling that, in the early twenty-first century, government proponents of the individual health insurance mandate would attempt to justify such an assertion of power on the basis of this Clause, they probably would have been the strongest opponents of ratification. They would have recognized how such an interpretation and application of the Necessary and Proper Clause would eviscerate the bedrock enumerated powers principle upon which the Constitution rests.

One of the *amicus curiae* briefs illustrates how using the Necessary and Proper Clause in the manner as suggested by the defendants would vitiate the enumerated powers principle (doc. 119). It points out that the defendants' are essentially admitting that the Act will have serious negative consequences, e.g., encouraging people to forego health insurance until medical services are needed, increasing premiums and costs for everyone, and thereby bankrupting the health insurance industry — unless the individual mandate is imposed. Thus, rather than being used to implement or facilitate enforcement of the Act's insurance industry reforms, the individual mandate is actually being used as the means to avoid the adverse consequences of the Act itself. Such an application of the Necessary and Proper Clause would have the perverse effect of enabling Congress to pass ill-conceived, or economically disruptive statutes, secure in the knowledge that the more dysfunctional the results of the statute are, the more essential or "necessary" the statutory fix would be. Under such a rationale, the more harm the statute does, the more power Congress could assume for itself under the Necessary and Proper Clause. This result would, of course, expand the Necessary and Proper Clause far beyond its original meaning, and allow Congress to exceed the powers specifically enumerated in Article I. Surely this is not what the Founders anticipated, nor how that Clause should operate.

Ultimately, the Necessary and Proper Clause vests Congress with the power and authority to exercise *means* which may not in and of themselves fall within an enumerated power, to accomplish *ends* that must be within an enumerated power. Although Congress' authority to act in furtherance of those ends is unquestionably broad, there are nevertheless "restraints upon the Necessary and Proper Clause authority." *See Raich, supra*, 545 U.S. at 39 (Scalia, J., concurring in judgment). Thomas Jefferson warned against an overly expansive application of cause and effect in interpreting the interplay between Congress' enumerated powers and the Necessary and Proper Clause:

> Congress are authorized to defend the nation. Ships are necessary for defense; copper is necessary for ships; mines necessary for copper; a company necessary to work mines; and who can doubt this reasoning who has ever played at "This is the House that Jack Built?"

Letter from Thomas Jefferson to Edward Livingston (Apr. 30, 1800), in 31 *The Papers of Thomas Jefferson* 547 (B. Oberg ed., 2004); *accord Comstock, supra*, 130 S. Ct. at 1966 (referencing same analogy and stating that the Necessary and Proper Clause "must be controlled by some limitations lest, as Thomas Jefferson warned, congressional powers become completely unbounded by linking one power to another *ad infinitum*") (Kennedy, J., concurring); *see also id.* at 1970 (explaining that the Clause "does not give Congress carte blanche," and it is the "obligation of this Court" to impose limitations) (Alito, J., concurring). As for where the restraints and limitations might be, it is — as is often the case—appropriate to look to Chief Justice Marshall, who first considered this issue and articulated the still-governing analysis:

> Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.
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> * * *
>
> [However,] should congress, in the execution of its powers, adopt measures which are prohibited by the constitution; or should congress, under the pretext of executing its powers, pass laws for the accomplishment of objects not intrusted to the government; it would become the painful duty of this tribunal, should a case requiring such a decision come before it, to say, that such an act was not the law of the land.

McCulloch, supra, 17 U.S. at 421, 423.

In light of *United States v. South-Eastern Underwriters*, 322 U.S. 533, 64 S. Ct. 1162, 88 L. Ed. 1440 (1944), the "end" of regulating the health care insurance industry (including preventing insurers from excluding or charging higher rates to people with pre-existing conditions) is clearly "legitimate" and "within the scope of the constitution." But, the means used to serve that end must be "appropriate," "plainly adapted," and not "prohibited" or inconsistent "with the letter and spirit of the constitution." These phrases "are not merely hortatory." *Raich, supra*, 545 U.S. at 39 (Scalia, J., concurring in judgment).

The Necessary and Proper Clause cannot be utilized to "pass laws for the accomplishment of objects" that are not within Congress' enumerated powers. As the previous analysis of the defendants' Commerce Clause argument reveals, the individual mandate is neither within the letter nor the spirit of the Constitution. To uphold that provision via application of the Necessary and Proper Clause would authorize Congress to reach and regulate far beyond the currently established "outer limits" of the Commerce Clause and effectively remove all limits on federal power. As the Supreme Court explained in *Printz*:

> When a "Law . . . for carrying into Execution" the Commerce Clause [violates other Constitutional principles], it is not a "Law . . . *proper* for carrying into Execution the Commerce Clause," and is thus, in the words of the Federalist, "merely an act of usurpation" which "deserves to be treated as such."

Printz, supra, 521 U.S. at 923-24 (citations and brackets omitted) (emphasis in original); *see also Comstock, supra*, 130 S. Ct. at 1967-68 ("It is of fundamental importance to consider whether essential attributes [of federalism embodied in the Constitution] are compromised by the assertion of federal power under the Necessary and Proper Clause; if so, that is a factor suggesting that the power is not one properly within the reach of federal power.") (Kennedy, J., concurring). Here, the "essential attributes" of the Commerce Clause limitations on the federal government's power would definitely be compromised by this assertion of federal power via the Necessary and Proper Clause. If Congress is allowed to define the scope of its power merely by arguing that a provision is "necessary" to avoid the negative consequences that will potentially flow from its *own* statutory enactments, the Necessary and Proper Clause runs the risk of ceasing to be the "perfectly harmless" part of the Constitution that Hamilton assured us it was, and moves that much closer to becoming the "hideous monster [with] devouring jaws" that he assured us it was not.

The defendants have asserted again and again that the individual mandate is absolutely "necessary" and "essential" for the Act to operate as it was intended by Congress. I accept that it is.[26] Nevertheless, the individual mandate falls outside the boundary of Congress' Commerce Clause authority and cannot be reconciled with a limited government of enumerated powers. By definition, it cannot be "proper."

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[26] As will be seen, the defendants' repeated assertions on this point impact the severability analysis.

(3) Constitutionality of the Individual Mandate

The individual mandate is outside Congress' Commerce Clause power, and it cannot be otherwise authorized by an assertion of power under the Necessary and Proper Clause. It is not Constitutional. Accordingly, summary judgment must be granted in favor of the plaintiffs on Count I.

(4) Severability

Having determined that the individual mandate exceeds Congress' power under the Commerce Clause, and cannot be saved by application of the Necessary and Proper Clause, the next question is whether it is severable from the remainder of the Act. In considering this issue, I note that the defendants have acknowledged that the individual mandate and the Act's health insurance reforms, including the guaranteed issue and community rating, will rise or fall together as these reforms "cannot be severed from the [individual mandate]." *See, e.g.*, Def. Opp. at 40. As explained in my order on the motion to dismiss: "the defendants concede that [the individual mandate] is absolutely necessary for the Act's insurance market reforms to work as intended. In fact, they refer to it as an 'essential' part of the Act at least fourteen times in their motion to dismiss." Thus, the only question is whether the Act's other, non-health-insurance-related provisions can stand independently or whether they, too, must fall with the individual mandate.[27]

Severability is a doctrine of judicial restraint, and the Supreme Court has applied and reaffirmed that doctrine just this past year: "'*Generally speaking*, when confronting a constitutional flaw in a statute, [courts] try to limit the solution to the problem,' severing any 'problematic portions while leaving the remainder intact.'" *Free Enterprise Fund v. Public Co. Accounting Oversight Board*, — U.S. —, 130 S. Ct. 3138, 3161, 177 L. Ed. 2d 706 (2010) (citation omitted) (emphasis added). Because the unconstitutionality of one provision of a legislative scheme "does not *necessarily* defeat or affect the validity of its remaining provisions," the "*normal* rule" is that partial invalidation is proper. *Id.* (citations omitted) (emphasis added). Where Congress has "enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not *ordinarily* cause Congress' overall intent to be frustrated." *New York, supra*, 505 U.S. at 186 (emphasis added). As the emphasized text shows, the foregoing is not a rigid and inflexible rule, but rather it is the general standard that applies in the typical case. However, this is anything but the typical case.

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[27] In considering this issue, I will at times borrow heavily from one of the *amicus* briefs filed in the case for it quite cogently and effectively sets forth the applicable standard and governing analysis of severability (doc. 123).

The question of severability ultimately turns on the nature of the statute at issue. For example, if Congress intended a given statute to be viewed as a bundle of separate legislative enactment or a series of short laws, which for purposes of convenience and efficiency were arranged together in a single legislative scheme, it is presumed that any provision declared unconstitutional can be struck and severed without affecting the remainder of the statute. If, however, the statute is viewed as a carefully-balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal, and if that goal would be undermined if a central part of the legislation is found to be unconstitutional, then severability is not appropriate. As will be seen, the facts of this case lean heavily toward a finding that the Act is properly viewed as the latter, and not the former.

The standard for determining whether an unconstitutional statutory provision can be severed from the remainder of the statute is well-established, and it consists of a two-part test. First, after finding the challenged provision unconstitutional, the court must determine if the other provisions can function independently and remain "fully operative as a law." *See Free Enterprise Fund, supra*, 130 S. Ct. at 3161. In a statute that is approximately 2,700 pages long and has several hundred sections — certain of which have only a remote and tangential connection to health care — it stands to reason that some (perhaps even most) of the remaining provisions can stand alone and function independently of the individual mandate. The defendants have identified several provisions that they believe can function independently: the prohibition on discrimination against providers who will not furnish assisted suicide services; an "Independence at Home" project for chronically ill seniors; a special Medicare enrollment period for disabled veterans; Medicare reimbursement for bone-marrow density tests; and provisions devised to improve women's health, prevent abuse, and ameliorate dementia [Def. Opp. at 40], as well as abstinence education and disease prevention [doc. 74 at 14]. And as was mentioned during oral argument, there is little doubt that the provision in the Act requiring employers to provide a "reasonable break time" and separate room for nursing mothers to go and express breast milk [Act § 4207] can function without the individual mandate. Importantly, this provision and many others are already in effect and functioning. However, the question is not whether these and the myriad other provisions can function as a technical or practical matter; instead, the "more relevant inquiry" is whether these provisions will comprise a statute that will function "in a manner consistent with the intent of Congress." *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685, 107 S. Ct. 1476, 94 L. Ed. 2d 661 (1987) (emphasis in original). Thus, the first step in the severability analysis requires (at least to some extent) that I try to infer Congress' intent. Although many of the remaining provisions, as just noted, can most likely function independently of the individual mandate, there is nothing to indicate that they can do so in the manner intended by Congress. The analysis at the second step of the severability test makes that conclusion pretty clear.

At this second step, reviewing courts may look to "the statute's text or historical context" to determine if Congress, had it been presented with a statute that did not contain the struck part, would have preferred to have no statute at all. *See Free Enterprise Fund, supra,* 130 S. Ct. at 3161-62. "Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *See Alaska Airlines, Inc., supra,* 480 U.S. at 684. But once again, that presupposes that the provisions left over function in a manner consistent with the main objective and purpose of the statute in the first place. *Cf. New York, supra,* 505 U.S. at 187 (unconstitutional provision held to be severable where the remaining statute "still serves Congress' *objective*" and the "*purpose* of the Act is not defeated by the invalidation" of the unconstitutional provision) (emphasis added). While this inquiry "can sometimes be 'elusive'" [*Free Enterprise Fund, supra,* 130 S. Ct. at 3161], on the unique facts of this particular case, the record seems to strongly indicate that Congress would not have passed the Act in its present form if it had not included the individual mandate. This is because the individual mandate was indisputably essential to what Congress was ultimately seeking to accomplish. It was, in fact, the keystone or lynchpin of the entire health reform effort. After looking at the "statute's text" (or, rather, its conspicuous lack of text) and the "historical record" [*see Free Enterprise Fund, supra,* 130 S. Ct. at 3162], there are two specific facts that are particularly telling in this respect.

First, the Act does not contain a "severability clause," which is commonly included in legislation to provide that if any part or provision is held invalid, then the rest of the statute will not be affected. Although it is true that the absence of such a clause, in and of itself, "does not raise a presumption against severability," [*New York, supra*, 505 U.S. at 186], that is not the same thing as saying that its absence is irrelevant to the analysis. In *INS v. Chadha*, 462 U.S. 919, 103 S. Ct. 2764, 77 L. Ed. 2d 317 (1983), for example, the Supreme Court concluded that it did not have to embark on the "elusive inquiry" of whether Congress intended the unconstitutional provision in that case to be severable from the rest of the statute because Congress included a severability clause with language that was plain and unambiguous. *See id.* at 931-32. And, in *Alaska Airlines, Inc., supra*, 480 U.S. at 686, the Court similarly held that the severability analysis is "eased" when there is a severability clause in the statute, such that only "strong evidence" can overcome it. By necessary implication, the evidence against severability need not be as strong to overcome the general presumption when there is no such clause.

The lack of a severability clause in this case is significant because one had been included in an earlier version of the Act, but it was removed in the bill that subsequently became law. "Where Congress includes [particular] language in an earlier version of a bill but deletes it prior to enactment, it may be presumed that the [omitted provision] was not intended." *Russello v. United States*, 464 U.S. 16, 23-24, 104 S. Ct. 296, 78 L. Ed. 2d 17 (1983). In other words, the severability clause was intentionally left out of the Act. The absence of a severability clause is further significant because the individual mandate was controversial all during the progress of the legislation and Congress was undoubtedly well aware that legal challenges were coming. Indeed, as noted earlier, even before the Act became law, several states had passed statutes declaring the individual mandate unconstitutional and purporting to exempt their residents from it; and Congress' own attorneys in the CRS had basically advised that the challenges might well have legal merit as it was "unclear" if the individual mandate had "solid constitutional foundation." *See* CRS Analysis, *supra*, at 3. In light of the foregoing, Congress' failure to include a severability clause in the Act (or, more accurately, its decision to not include one that had been included earlier) can be viewed as strong evidence that Congress recognized the Act could not operate *as intended* without the individual mandate.

Moreover, the defendants have conceded that the Act's health insurance reforms cannot survive without the individual mandate, which is extremely significant because the various insurance provisions, in turn, are the very heart of the Act itself. The health insurance reform provisions were cited repeatedly during the health care debate, and they were instrumental in passing the Act. In speech after speech President Obama emphasized that the legislative goal was "health *insurance* reform" and stressed how important it was that Congress fundamentally reform how health insurance companies do business, and "protect every American from the worst practices of the insurance industry." *See*, for example, Remarks of President Obama, The State of the Union, delivered Jan. 27, 2009.[28] Meanwhile, the Act's supporters in the Senate and House similarly spoke repeatedly and often of the legislative efforts as being the means to comprehensively reform the health insurance industry.[29]

To be sure, the words "protection" and "affordable" in the title of the Act itself are inextricably tied to the health insurance reform provisions (and the individual mandate in particular), as the defendants have emphasized throughout the course of this litigation. *See, e.g.*, Def.

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[28] *See also, e.g.*, The White House, Office of the Press Secretary, Official Transcript of President Obama's News Conference, July 22, 2009, available at: http://www.whitehouse.gov/the-press-office/news-conference-president-july-22-20 09; The White House, Office of the Press Secretary, Official Transcript of President Obama's Remarks at Health Care Reform Town Hall, July 23, 2009, available at: http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-at-Health-C are-Reform-Town-Hall/.

[29] *See, e.g.*, David Welna, *Analyzing Democrats' Word Shift on Health Care*, National Public Radio, Nov. 17, 2009 (reporting that during the health care reform debate the Act's proponents referred to the ongoing efforts as "health insurance reform," which, according to the head of a nonpartisan health care organization, "is a much more accurate label" as the "health care makeover has ended up being largely about [reforming] insurance companies"), available at http://www.npr.org/templates/story/story.php?storyId=1204647 01.

Mem. at 1 ("Focusing on insurance industry practices that prevented millions of Americans from obtaining *affordable* insurance, the Act bars insurers from denying coverage to those with pre-existing conditions or from charging discriminatory premiums on the basis of medical history. Congress recognized that these reforms of insurance industry practices were required to *protect* consumers . . . ") (emphasis added); Reply in Support of Defendants' Motion to Dismiss, filed August 27, 2010 (doc. 74), at 21 (stating that the individual mandate "is necessary for Congress's insurance reforms to work"; that "those provisions *protect* millions of Americans"; and that "Congress plainly regarded their *protection* as a core objective of the Act") (emphasis added). The defendants have further identified and highlighted the essential role that the individual mandate played in the overall regulatory reform of the interstate health care and health insurance markets:

> [T]he [individual mandate] is essential to the Act's comprehensive scheme to ensure that health insurance coverage is available and *affordable*. In addition to regulating industry underwriting practices, the Act promotes availability and *affordability* through (a) "health benefit exchanges" that enable individuals and small businesses to obtain competitive prices for health insurance; (b) financial incentives for employers to offer expanded insurance coverage, (c) tax credits to low-income and middle-income individuals and families, and (d) extension of Medicaid to additional low-income individuals. *The [individual mandate] works in tandem with these and other reforms. . . .*

> Congress thus found that failure to regulate the decision to forgo insurance . . . would undermine the "comprehensive regulatory regime" in the Act. . . .
>
> *[The individual mandate] is essential to Congress's overall regulatory reform of the interstate health care and health insurance markets . . . is "essential" to achieving key reforms of the interstate health insurance market . . . [and is] necessary to make the other regulations in the Act effective.*

Memorandum in Support of Defendants' Motion to Dismiss, filed June 17, 2010 (doc. 56-1), at 46-48 (emphasis added).

Congress has also acknowledged in the Act itself that the individual mandate is absolutely "essential" to the Act's overarching goal of expanding the availability of affordable health insurance coverage and protecting individuals with pre-existing medical conditions:

> [I]f there were no [individual mandate], many individuals would wait to purchase health insurance until they needed care . . . The [individual mandate] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

Act § 1501(a)(2)(I) (emphasis added).

In other words, the individual mandate is indisputably necessary to the Act's insurance market reforms, which are, in turn, indisputably necessary to the purpose of the Act. This is obviously a very different situation than in *Alaska Airlines, Inc., supra,* 480 U.S. at 694 n.18 and 696 (unconstitutional provision severed from rest of statute where the provision was "uncontroversial," and the debate on the final bill demonstrated its "relative unimportance"), and is more in line with the situation alluded to in *New York, supra*, 505 U.S. at 187 (suggesting by implication that the entire legislation should be struck when "the purpose of the Act is . . . defeated by the invalidation" of one of its provisions).

In weighing the Act's provisions and attempting to discern legislative intent and purpose, I have kept in mind the rationale underlying the severability doctrine, which the Supreme Court has described as follows:

> Three interrelated principles inform our approach to remedies. First, we try not to nullify more of a legislature's work than is necessary, for we know that a ruling of unconstitutionality frustrates the intent of the elected representatives of the people. . . . Second, mindful that our constitutional mandate and institutional competence are limited, we restrain ourselves from rewriting [a] law to conform it to constitutional requirements even as we strive to salvage it . . . Third, the touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature.

Ayotte v. Planned Parenthood of Northern New England, 546 U.S. 321, 329-30, 126 S. Ct. 961, 163 L.

Ed. 2d 812 (2006) (citations and brackets omitted). The first principle merely reflects the general judicial policy discussed at the beginning of this section; that is, because a ruling of unconstitutionality frustrates the intent of democratically-elected representatives of the people, the "normal rule" — in the "normal" case — will ordinarily require that as little of a statute be struck down as possible. The two other principles, however, require closer analysis.

As for the second principle, the *Ayotte* Court explained:

> Our ability to devise a judicial remedy that does not entail quintessentially legislative work often depends on how clearly we have already articulated the background constitutional rules at issue . . . But making distinctions in a murky constitutional context, or where line-drawing is inherently complex, may call for a "far more serious invasion of the legislative domain" than we ought to undertake.

Supra, 546 U.S. at 329-30. Thus, cleanly and clearly severing an unconstitutional provision is one thing, but having to re-balance a statutory scheme by engaging in quasi-legislative "line drawing" is a "'far more serious invasion of the legislative domain'" than courts should undertake. *See id.* This analysis merges into the third principle identified in *Ayotte*:

> After finding an application or portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all? All the while, we are wary of legislatures who would rely on our

> intervention, for it would certainly be dangerous if the legislature could set a net large enough to catch all possible offenders, and leave it to the courts to step inside to announce to whom the statute may be applied. This would, to some extent, substitute the judicial for the legislative department of the government.

Id. at 330 (citations and brackets omitted).

Severing the individual mandate from the Act along with the other insurance reform provisions — and in the process reconfiguring an exceedingly lengthy and comprehensive legislative scheme — cannot be done consistent with the principles set out above. Going through the 2,700-page Act line-by-line, invalidating dozens (or hundreds) of some sections while retaining dozens (or hundreds) of others, would not only take considerable time and extensive briefing, but it would, in the end, be tantamount to rewriting a statute in an attempt to salvage it, which is foreclosed by *Ayotte, supra.* Courts should not even attempt to do that. It would be impossible to ascertain on a section-by-section basis if a particular statutory provision could stand (and was intended by Congress to stand) independently of the individual mandate. The interoperative effects of a partial deletion of legislative provisions are often unforseen and unpredictable. For me to try and "second guess" what Congress would want to keep is almost impossible. To highlight one of many examples, consider the Internal Revenue Service Form 1099 reporting requirement, which requires that businesses, including sole proprietorships, issue 1099 tax forms to individuals or corporations to whom or which they have paid more than $600 for goods or services in any given tax year [Act § 9006]. This provision has no discernable connection to health care and was intended to generate offsetting revenue for the Act, the need of which is greatly diminished in the absence of the "health benefit exchanges," subsidies and tax credits, and Medicaid expansion (all of which, as the defendants have conceded, "work in tandem" with the individual mandate and other insurance reform provisions). How could I possibly determine if Congress intended the 1099 reporting provision to stand independently of the insurance reform provisions? Should the fact that it has been widely criticized by both Congressional supporters and opponents of the Act and the fact that there have been bipartisan efforts to repeal it factor at all into my determination?

In the final analysis, this Act has been analogized to a finely crafted watch, and that seems to fit. It has approximately 450 separate pieces, but one essential piece (the individual mandate) is defective and must be removed. It cannot function as originally designed. There are simply too many moving parts in the Act and too many provisions dependent (directly and indirectly) on the individual mandate and other health insurance provisions — which, as noted, were the chief engines that drove the entire legislative effort — for me to try and dissect out the proper from the improper, and the able-to-stand-alone from the unable-to-stand-alone. Such a quasi-legislative undertaking would be particularly inappropriate in light of the fact that any statute that might conceivably be left over after this analysis is complete would plainly not serve

Congress' main purpose and primary objective in passing the Act. The statute is, after all, called "The Patient Protection and Affordable Care Act," not "The Abstinence Education and Bone Marrow Density Testing Act." The Act, like a defectively designed watch, needs to be redesigned and reconstructed by the watchmaker.

If Congress intends to implement health care reform — and there would appear to be widespread agreement across the political spectrum that reform is needed — it should do a comprehensive examination of the Act and make a legislative determination as to which of its hundreds of provisions and sections will work as intended without the individual mandate, and which will not. It is Congress that should consider and decide these quintessentially legislative questions, and not the courts.

In sum, notwithstanding the fact that many of the provisions in the Act can stand independently without the individual mandate (as a technical and practical matter), it is reasonably "evident," as I have discussed above, that the individual mandate was an essential and indispensable part of the health reform efforts, and that Congress did not believe other parts of the Act could (or it would want them to) survive independently. I must conclude that the individual mandate and the remaining provisions are all inextricably bound together in purpose and must stand or fall as a single unit. The individual mandate cannot be severed. This conclusion is reached with full appreciation for the "normal rule" that reviewing courts should ordinarily refrain from invalidating more than the unconstitutional part of a statute, but non-severability is required based on the unique facts of this case and the particular aspects of the Act. This is not a situation that is likely to be repeated.

(5) Injunction

The last issue to be resolved is the plaintiffs' request for injunctive relief enjoining implementation of the Act, which can be disposed of very quickly.

Injunctive relief is an "extraordinary" [*Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312, 102 S. Ct. 1798, 72 L. Ed. 2d 91 (1982)], and "drastic" remedy [*Aaron v. S.E.C.*, 446 U.S. 680, 703, 100 S. Ct. 1945, 64 L. Ed. 2d 611 (1980) (Burger, J., concurring)]. It is even more so when the party to be enjoined is the federal government, for there is a long-standing presumption "that officials of the Executive Branch will adhere to the law as declared by the court. As a result, the declaratory judgment is the functional equivalent of an injunction." *See Comm. On Judiciary of U.S. House of Representatives v. Miers*, 542 F.3d 909, 911 (D.C. Cir. 2008); *accord Sanchez-Espinoza v. Reagan*, 770 F.2d 202, 208 n.8 (D.C. Cir. 1985) ("declaratory judgment is, in a context such as this where federal officers are defendants, the practical equivalent of specific relief such as an injunction . . . since *it must be presumed that federal officers will adhere to the law as declared by the court*") (Scalia, J.) (emphasis added).

There is no reason to conclude that this presumption should not apply here. Thus, the award of declaratory relief is adequate and separate injunctive relief is not necessary.

CONCLUSION

The existing problems in our national health care system are recognized by everyone in this case. There is widespread sentiment for positive improvements that will reduce costs, improve the quality of care, and expand availability in a way that the nation can afford. This is obviously a very difficult task. Regardless of how laudable its attempts may have been to accomplish these goals in passing the Act, Congress must operate within the bounds established by the Constitution. Again, this case is not about whether the Act is wise or unwise legislation. It is about the Constitutional role of the federal government.

For the reasons stated, I must reluctantly conclude that Congress exceeded the bounds of its authority in passing the Act with the individual mandate. That is not to say, of course, that Congress is without power to address the problems and inequities in our health care system. The health care market is more than one sixth of the national economy, and without doubt Congress has the power to reform and regulate this market. That has not been disputed in this case. The principal dispute has been about how Congress chose to exercise that power here.[30]

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[30] On this point, it should be emphasized that while the individual mandate was clearly "necessary and essential" to the Act as drafted, it is not "necessary and essential" to health care reform in general. It is undisputed that there are various other (Constitutional) ways to accomplish what Congress wanted to do. Indeed, I note that in 2008, then-Senator Obama supported

Because the individual mandate is unconstitutional and not severable, the entire Act must be declared void. This has been a difficult decision to reach, and I am aware that it will have indeterminable implications. At a time when there is virtually unanimous agreement that health care reform is needed in this country, it is hard to invalidate and strike down a statute titled "The Patient Protection and Affordable Care Act." As Judge Luttig wrote for an *en banc* Fourth Circuit in striking down the "Violence Against Women Act" (before the case was appealed and the Supreme Court did the same):

> No less for judges than for politicians is the temptation to affirm any statute so decorously titled. We live in a time when the lines between

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a health care reform proposal that did not include an individual mandate because he was at that time strongly opposed to the idea, stating that "if a mandate was the solution, we can try that to solve homelessness by mandating everybody to buy a house." *See* Interview on CNN's American Morning, Feb. 5, 2008, transcript available at: http://transcripts.cnn.com/TRANSCRIPTS/0802/05/ltm.02.html. In fact, he pointed to the similar individual mandate in Massachusetts — which was imposed under the state's police power, a power the federal government does not have — and opined that the mandate there left some residents "worse off" than they had been before. *See* Christopher Lee, *Simple Question Defines Complex Health Debate*, Washington Post, Feb. 24, 2008, at A10 (quoting Senator Obama as saying: "In some cases, there are people [in Massachusetts] who are paying fines and still can't afford [health insurance], so now they're worse off than they were . . . They don't have health insurance, and they're paying a fine . . .").

> law and politics have been purposefully blurred to serve the ends of the latter. And, when we, as courts, have not participated in this most perniciously machiavellian of enterprises ourselves, we have acquiesced in it by others, allowing opinions of law to be dismissed as but pronouncements of personal agreement or disagreement. The judicial decision making contemplated by the Constitution, however, unlike at least the politics of the moment, emphatically is not a function of labels. If it were, the Supreme Court assuredly would not have struck down the "Gun-Free School Zones Act," the "Religious Freedom Restoration Act," the "Civil Rights Act of 1871," or the "Civil Rights Act of 1875." And if it ever becomes such, we will have ceased to be a society of law, and all the codification of freedom in the world will be to little avail.

Brzonkala, supra, 169 F.3d at 889.

In closing, I will simply observe, once again, that my conclusion in this case is based on an application of the Commerce Clause law as it exists pursuant to the Supreme Court's current interpretation and definition. Only the Supreme Court (or a Constitutional amendment) can expand that.

For all the reasons stated above and pursuant to Rule 56 of the Federal Rules of Civil Procedure, the plaintiffs' motion for summary judgment (doc. 80) is hereby GRANTED as to its request for declaratory relief on Count I of the Second Amended Complaint, and DENIED as to its request for injunctive relief; and the defendants' motion for summary judgment (doc. 82) is hereby GRANTED on Count IV of the Second Amended Complaint. The respective cross-motions are each DENIED.

In accordance with Rule 57 of the Federal Rules of Civil Procedure and Title 28, United States Code, Section 2201(a), a Declaratory Judgment shall be entered separately, declaring "The Patient Protection and Affordable Care Act" unconstitutional.

DONE and ORDERED this 31st day of January, 2011.

/s/ Roger Vinson

ROGER VINSON

Senior United States District Judge

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA PENSACOLA DIVISION

Case No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

October 14, 2010

ORDER AND MEMORANDUM OPINION

Now pending is the defendants' motion to dismiss (doc. 55). This motion seeks dismissal of Counts One, Two, Three, and Six of the plaintiffs' amended complaint for lack of subject matter jurisdiction (pursuant to Rule 12(b)(1), Fed. R. Civ. P.), and dismissal of all counts in the amended complaint for failure to state a claim upon which relief can be granted (pursuant o Rule 12(b)(6), Fed. R. Civ. P.). The plaintiffs have filed a response in opposition, and the defendants have filed a reply to that response. A hearing was held in this matter on September 14, 2010.

I. INTRODUCTION

This litigation — one of many filed throughout the country — raises a facial Constitutional challenge to the federal healthcare reform law, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (the "Act"). It has been filed by sixteen state Attorneys General and four state Governors (the "state plaintiffs");[1] two private citizens, Mary Brown and Kaj Ahlburg (the "individual plaintiffs"); and the National Federation of Independent Business ("NFIB") (together, the "plaintiffs"). The defendants are the United States Department of Health and Human Services, Department of Treasury, Department of Labor, and their respective secretaries (together, the "defendants").

Before addressing the plaintiffs' allegations, and the arguments in support of the defendants' motion to dismiss, I will take a moment to emphasize preliminarily what this case is, and is not, about.

The Act is a controversial and polarizing law about which reasonable and intelligent people can disagree in good faith. There are some who believe it will expand access to medical treatment, reduce costs, lead to improved care, have a positive effect on the national economy, and reduce the annual federal budgetary deficit, while others expect that it will do exactly the opposite. Some say it was the product of an open and honest process between lawmakers sufficiently acquainted with its myriad provisions, while others contend that it was drafted behind closed doors and pushed through Congress by parliamentary tricks, late night weekend votes, and last minute deals among members of Congress who did not read or otherwise know what was in it. There are some who believe the Act is designed to strengthen the private insurance market and build upon free market principles, and others who believe it will greatly expand the size and reach of the federal government and is intended to create a socialized government healthcare system.

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[1] The state plaintiffs represent: Alabama, Alaska, Arizona, Colorado, Florida Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North and South Dakota, Pennsylvania, South Carolina, Texas, Utah, and Washington.

While these competing arguments would make for an interesting debate and discussion, it is not my task or duty to wade into the thicket of conflicting opinion on any of these points of disagreement. For purposes of this case, it matters not whether the Act is wise or unwise, or whether it will positively or negatively impact healthcare and the economy. Nor (except to the limited extent noted in Part III.A(7) *infra*) am I concerned with the manner in which it was passed into law. My review of the statute is not to question or second guess the wisdom, motives, or methods of Congress. I am only charged with deciding if the Act is Constitutional. If it is, the legislation must be upheld — even if it is a bad law. *United States v. Butler*, 297 U.S. 1, 79, 56 S. Ct. 312, 80 L. Ed. 477 (1936) ("For the removal of unwise laws from the statute books appeal lies, not to the courts, but to the ballot and to the processes of democratic government") (Stone, J., dissenting). Conversely, if it is unconstitutional, the legislation must be struck down — even if it is a good law. *Bailey v. Drexel Furniture Co. (Child Labor Tax Case)*, 259 U.S. 20, 37, 42 S. Ct. 449, 66 L. Ed. 817 (1922) (reviewing court must strike down unconstitutional law even though that law is "designed to promote the highest good. The good sought in unconstitutional legislation is an insidious feature, because it leads citizens and legislators of good purpose to promote it, without thought of the serious breach it will make in the ark of our covenant, or the harm which will come from breaking down recognized standards.").

At this stage in the case, however, my job is much simpler and more narrow than that. In ruling on the defendants' motion to dismiss, I must only decide if this court has jurisdiction to consider some of the plaintiffs' claims, and whether each of the counts of the amended complaint states a plausible claim for relief.

II. BACKGROUND

As Congress has recognized: "By most measures, we have the best medical care system in the world." H.R. Rep. No. 111-443, pt. 1. However, at the same time, no one can deny that there are significant and serious problems. Costs are high and millions do not have insurance. Lack of health insurance can preclude the uninsured from accessing preventative care. If and when the uninsured are injured or become ill, they receive treatment, as the defendants acknowledge, because in this country medical care is generally not denied due to lack of insurance coverage or inability to pay. However, the costs that are incurred to treat the uninsured are sometimes left unpaid — to the tune of $43 billion in 2008 (which is less than 2% of all national healthcare expenditures for that year). The costs of uncompensated care are passed along to market participants in the form of higher costs and raised premiums, which, in turn, can help perpetuate the cycle (or the "premium spiral," as the defendants call it) and add to the number of uninsured. It was against this backdrop that Congress passed the Act.

A. The Legislative Scheme

At nearly 2,700 pages, the Act is very lengthy and includes many provisions, only a few of which are specifically at issue in this litigation. Chief among them is Section 1501, which, beginning in 2014, will require that all citizens (with stated exceptions) obtain federally-approved health insurance, or pay a monetary penalty (the "individual mandate"). This provision is necessary, according to Congress and the defendants, to lower premiums (by spreading risks across a much larger pool) and to meet "a core objective of the Act," which is to expand insurance coverage to the uninsured by precluding the insurance companies from refusing to cover (or charging exorbitant rates to) people with pre-existing medical conditions. Without the individual mandate and penalty in place, the argument goes, people would simply "game the system" by waiting until they get sick or injured and only then purchase health insurance (that insurers must by law now provide), which would result in increased costs for the insurance companies. This is known as "the moral hazard." The increased costs would ultimately be passed along to consumers in the form of raised premiums, thereby creating market pressures that would (arguably) inevitably drive the health insurance industry into extinction. The plaintiffs allege that regardless of whether the individual mandate is well-meaning and essential to the Act, it is unconstitutional and will have both a "profound and injurious impact" on the states, individuals, and businesses.

The plaintiffs object to several interrelated portions of the Act as well. First, the Act significantly alters and expands the Medicaid program. Created in 1965, Medicaid is a cooperative federal-state program that provides for federal financial assistance (in the form of matching funds) to states that elect to provide medical care to needy persons. The Act will add millions of new enrollees to the states' Medicaid rolls by expanding the program to include all individuals under the age of 65 with incomes up to 133% of the federal poverty line. Second, the Act provides for creation of "health benefit exchanges" designed to allow individuals and small businesses to leverage their buying power to obtain competitive prices. The Act contemplates that these exchanges will be set up and operated by the states, or by the federal government if the states elect not to do so. And lastly, the Act requires that the states (along with other "large employers") provide their employees with a prescribed minimum level of health insurance coverage (the "employer mandate"). The plaintiffs allege that these several provisions violate the Constitution and state sovereignty by coercing and commandeering the states and depriving them of their "historic flexibility" to run their state government, healthcare, and Medicaid programs. The plaintiffs anticipate that these and various other provisions in the Act will cost Florida (and the other states similarly) billions of dollars between now and the year 2019, not including the administrative costs it will take to implement the Act, and that these costs will only increase in the subsequent years. In short, the plaintiffs contend that the legislation is coercive, intrusive, and could bankrupt the states.[2]

B. This Lawsuit and the Motion to Dismiss

The plaintiffs advance six causes of action in their amended complaint, and they seek declaratory and injunctive relief with respect to each. They contend that the Act violates the Constitution in the following ways: (1) the individual mandate and concomitant penalty exceed Congress's authority under the Commerce Clause and violate the Ninth and Tenth Amendments (Count I); (2) the individual mandate and penalty violate substantive due process under the Fifth Amendment (Count II); (3) "alternatively," if the penalty imposed for failing to comply with the individual mandate is found to be a tax, it is an unconstitutional unapportioned capitation or direct tax in violation of U.S. Const. art. I, § 9, cl. 4, and the Ninth and Tenth Amendments (Count III); (4) the Act coerces and commandeers the states with respect to Medicaid by altering and expanding the program in violation of Article I and the Ninth and Tenth Amendments (Count IV); (5) it coerces and commandeers with respect to the health benefit exchanges in violation of Article I and the Ninth and Tenth Amendments (Count V); and (6) the employer mandate interferes with the states' sovereignty as large employers and in the performance of government functions in violation of Article I and the Ninth and Tenth Amendments (Count VI). *See generally* Amended Complaint ("Am. Compl.") (doc. 42).

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[2] Not all states feel this way, and there is even a division within a few of the plaintiff states. Three Attorneys General and four Governors previously requested leave to participate in this case as *amici curiae*, and they have indicated that the favor the changes the Act will bring as they believe the new legislation will save money and reduce their already overburdened state budgets (docs. 57, 59).

The defendants seek to have the complaint dismissed on numerous grounds; four of the counts for lack of jurisdiction (under Rule 12(b)(1)), and all six of them for failure to state a claim upon which relief can be granted (under Rule 12(b)(6)). With respect to jurisdiction, the defendants contend that for the challenges to the individual mandate and employer mandate (Counts I, II, and VI), the plaintiffs lack standing; the claims are not ripe; and the claims are barred by the Anti-Injunction Act. (By not raising similar arguments for Counts IV and V, the defendants appear to impliedly concede that those counts allege injuries that are immediately ripe for review). As for the plaintiffs' "alternative" cause of action contending that, if the individual mandate penalty is deemed to be a tax, then it is an impermissible and unconstitutional one (Count III), the defendants maintain that, too, is precluded by the Anti-Injunction Act.

If the foregoing jurisdictional challenges fail, the defendants go on to assert that those causes of action, and all others, fail to state a claim for which relief can be granted.

III. DISCUSSION

A. Is the "Penalty" for Non-Compliance with the Individual Mandate Actually a "Tax" for Constitutional Analysis?

A fundamental issue overlaps the defendants' challenges to several of the plaintiffs' claims, and that is whether the individual mandate penalty is a "tax" within Congress's broad taxing power and thus subject to the Anti-Injunction Act, or instead, a "penalty" that must be authorized, if at all, by Congress's narrower Commerce Clause power. Because of the importance of this issue, I will analyze it first and at some length.

The defendants contend that the individual mandate penalty is a tax that is sustainable under Congress's expansive power to tax for the general welfare. U.S. Const. art I, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the . . . general Welfare"). The plaintiffs urge that, if it is a tax, it is an unconstitutional one. The defendants maintain that the plaintiffs have no standing to raise the claim at this point in time because of the Anti-Injunction Act.

The Anti-Injunction Act [26 U.S.C. § 7421(a)] provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person . . . ." The remedy for challenging an improper tax is a post-collection suit for refund. As the Supreme Court has explained:

> The Anti-Injunction Act . . . could scarcely be more explicit — "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court . . ." The Court has interpreted the principal purpose of this language to be the protection of the Government's need to assess and collect taxes as expeditiously as possible with a minimum of preenforcement judicial interference, "and to require that the legal right to the disputed sums be determined in a suit for refund." The Court has also identified "a collateral objective of the Act — protection of the collector from litigation pending a suit for refund."

Bob Jones Univ. v. Simon, 416 U.S. 725, 736-37, 94 S. Ct. 2038, 40 L. Ed. 2d 496 (1974) (citations omitted); *accord, e.g., United States v. Clintwood Elkhorn Min. Co.*, 553 U.S. 1, 10, 128 S. Ct. 1511, 170 L. Ed. 2d 392 (2008) ("[The Anti- Injunction Act] commands that (absent certain exceptions) 'no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court,'" even if the tax is alleged to be unconstitutional, which means "the taxpayer must succumb to an unconstitutional tax, and seek recourse only after it has been unlawfully exacted"); *Enochs v. Williams Packing & Navigation Co.*, 370 U.S. 1, 7, 82 S. Ct. 1125, 8 L. Ed. 2d 292 (1962) (explaining that the "manifest purpose" of the Anti-Injunction Act "is to permit the United States to assess and collect taxes alleged to be due without judicial intervention, and to require that the legal right to the disputed sums be determined in a suit for refund. In this manner the United States is assured of prompt collection of its lawful revenue."). The Anti- Injunction Act, in short, applies to "truly revenue-raising tax statutes," see Bob *Jones Univ., supra,* 416 U.S. at 743, and seeks "protection of the revenues" pending a suit for refund. *See id.* at 737, 740.

Because the individual mandate does not go into effect until 2014, which means the penalty for noncompliance could not be assessed until that time, the Anti-Injunction Act, if it applies, could render much of this case premature and inappropriate as any injunctive or declaratory relief in favor of the plaintiffs could hinder collection of tax revenue. *See id.* at 732 n.7, 738-39 (where the outcome of a suit seeking injunctive or declaratory relief will prevent assessment and collection of tax revenue, the case "falls within the literal scope and the purposes of the [Anti-Injunction Act]"). Consequently, whether the individual mandate penalty is a tax is an important question that not only implicates jurisdiction (vis-a-vis the Anti- Injunction Act), and is not only the specific basis of one of the plaintiffs' causes of action, but it also goes to the merits of the individual mandate-related challenges of Counts One and Two (that is, whether the penalty can be justified by, and enforced through, Congress's indisputably broad taxing power), or whether, instead, the penalty must pass Constitutional muster, if at all, under the more limited Commerce Clause authority. As noted, I should, and will, consider this significant issue at the outset.[3]

(1) Revenue-raising vs. regulatory

The plaintiffs contend that the individual mandate penalty is not a "true tax" because, among other things, it will (at most) "generate only 'some revenue,' and then only as an incident to some persons' failure to obey the law." *See* Plaintiffs' Memorandum in Opposition to Defendants' Motion to Dismiss ("Pl. Mem."), at 19 (doc. 68). In other words, because its primary purpose is regulatory — and will only raise "little" revenue — it is not a tax as the term is generally understood. It is true, as held in certain of the early tax cases to which the plaintiffs cite, *see, e.g., Lipke v. Lederer*, 259 U.S. 557, 42 S. Ct. 549, 66 L. Ed. 1061 (1922); *Hill v. Wallace*, 259 U.S. 44, 42 S. Ct. 453, 66 L. Ed. 822 (1922), that the Supreme Court once drew distinctions between regulatory and revenue-raising taxes. However, those holdings had a very short shelf-life. As noted in *Bob Jones Univ., supra*, which cited to *Lipke* and *Hill* for that position, "the Court . . . subsequently abandoned such distinctions." 416 U.S. at 741 n.12; *see also id.* at 743 (further stating that the cases were "of narrow scope" and "produced a prompt correction in course"). Succeeding case law recognized that "[e]very tax is in some measure regulatory. To some extent it interposes an economic impediment to the activity taxed as compared with others not taxed. But a tax is not any the less a tax because it has a regulatory effect." *Sonzinsky v. United States*, 300 U.S. 506, 513, 57 S. Ct. 554, 81 L. Ed. 772 (1937); *see also id.* ("it has long been established that an Act of Congress which on its face purports to be an exercise of the taxing power is not any the less so because the tax . . . tends to restrict or suppress the thing taxed"). Thus, as the law currently exists, "[i]t is beyond serious question that a tax does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed. The principle applies even though the revenue obtained is obviously negligible, or the revenue purpose of the tax may be secondary."

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[3] The plaintiffs have briefly suggested that the Anti-Injunction does not apply to this case because their challenge "is to the individual mandate itself" and not the "incidental penalty that accompanies the individual mandate." While it is true that the language of the Anti-Injunction Act only prohibits suits "for the purpose of restraining the assessment or collection of any tax," which would not apply to the individual mandate for every citizen to maintain healthcare coverage, the mandate and penalty clearly work in tandem. If the penalty is a legitimate tax, striking the individual mandate down will necessarily impede assessment and collection of tax revenue. The Anti-Injunction Act is not limited to direct and actual tax assessment or collection; the Eleventh Circuit and other courts have held that the statute also reaches activities that may "eventually" impede the collection of revenue (even I indirectly). *See*, e.g., Gulden v. United States, 287 Fed. Appx. 813, 815-17 (11t Cir. 2008) (explaining that the Anti-Injunction Act is "interpreted broadly" an "bars not only suits that directly seek to restrain the assessment or collection of taxes, but also suits that seek to restrain . . . activities 'which are intended to or may culminate in the assessment or collection of taxes'") (citation omitted) *Judicial Watch Inc. v. Rossotti*, 317 F.3d 401, 405 (4th Cir. 2003) ("it is clear that the Anti-Injunction Act extends beyond the mere assessment and collection of taxes to embrace other activities," such as those that may eventually "culminate in the assessment or collection of taxes").

United States v. Sanchez, 340 U.S. 42, 44, 71 S. Ct. 108, 95 L. Ed. 47 (1950); *accord United States v. Kahriger*, 345 U.S. 22, 27 n.3, 28, 73 S. Ct. 510, 97 L. Ed. 754 (1953) (holding same and sustaining federal gambling tax even though its proponents sought to hinder the activity at issue and "'indulge[d] the hope that the imposition of this type of tax would eliminate that kind of activity'"), overruled on other grounds, *Marchetti v. United States*, 390 U.S. 39, 88 S. Ct. 697, 19 L. Ed. 2d 889 (1968). The elimination of the "regulatory vs. revenue-raising" test does not necessarily mean, however, that the exaction at issue in this case is a "tax."

(2) The Court's role in ascertaining what Congress intended

In deciding this specific question, I will start from the assumption (only for the analysis of whether it is a tax) that Congress could have used its broad taxing power to impose the exaction and that, if it had clearly (or even arguably) intended to do so, then the exaction would have been sustainable under its taxing authority. *See Kahriger, supra*, 345 U.S. at 28, 31 ("As is well known, the constitutional restraints on taxing are few," and courts are generally "without authority to limit the exercise of the taxing power"); *see also United States v. Ptasynski*, 462 U.S. 74, 103 S. Ct. 2239, 76 L. Ed. 2d 427 (1983) (observing that "Congress's power to tax is virtually without limitation").[4] However, that is not what happened here. Although factually dissimilar, on this point I find instructive the early case of *Helwig v. United States*, 188 U.S. 605, 23 S. Ct. 427, 47 L. Ed. 614 (1903). At issue in that case was a federal law that required importers to pay a duty on imported items based on their declared value, plus "a further sum" for any item subsequently found to have been inadequately valued. The sole question the Supreme Court was called upon to decide was whether, for jurisdictional purposes, the so-called "further sum" was "revenue from imports or tonnage" (i.e., a tax), or whether it was in the nature of a penalty. The Court stated:

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[4] *But see* the discussion with respect to Count Three, Part III.C(4) *infra*.

> Although the statute, under § 7, *supra*, terms the money demanded as 'a further sum,' and does not describe it as a penalty, still the use of those words does not change the nature and character of the enactment. *Congress may enact that such a provision shall not be considered as a penalty or in the nature of one, . . . and it is the duty of the court to be governed by such statutory direction*, but the intrinsic nature of the provision remains, and, *in the absence of any declaration by Congress affecting the manner in which the provision shall be treated*, courts must decide the matter in accordance with their views of the nature of the act.

Id. at 612-13 (emphasis added). In concluding that the provision was a penalty, the Court stated that, based on the statutory language and its application to the facts of the case, it was "impossible . . . to hold this provision to be other than penal in its nature." *Id.* at 613. To be clear, it is *not* necessarily significant for our purposes that *Helwig* found the "further sum" to be in the nature of a penalty and not a tax; rather, what is significant is what the Supreme Court said along the way to getting there. In reaching its conclusion, the Court made it a point to stress — as it did in the emphasized portion quoted above — that regardless of the "ordinary or general meaning of the words" in the statute, and regardless of the "nature and character of the enactment," the exaction would *not* have been found a penalty if Congress intended otherwise. Thus, "[i]f it clearly appear that it is the will of Congress that the provision shall not be regarded as in the nature of a penalty, *the court must be governed by that will.*" *Id.* (emphasis added).

As applied to the facts of this case, *Helwig* can be interpreted as concluding that, regardless of whether the exaction could otherwise qualify as a tax (based on the dictionary definition or "ordinary or general meaning of the word"), it cannot be regarded as one if it "clearly appears" that Congress did not intend it to be. In this case, there are several reasons (perhaps none dispositive alone, but convincing in total) why it is inarguably clear that Congress did not intend for the exaction to be regarded as a tax.[5]

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[5] Although it only matters what Congress intended, I note for background purposes that before the Act was passed into law, one of its chief proponents, President Barack Obama, strongly and emphatically denied that the penalty was a tax. When confronted with the dictionary definition of a "tax" during a much publicized interview widely disseminated by all of the news media, and asked how the penalty did not meet that definition, the President said it was "absolutely not a tax" and, in fact, "[n]obody considers [it] a tax increase." *See, e.g.*,

(3) Congress did not call it a tax, despite knowing how to do so

In addition to the Act, there were several healthcare reform bills introduced and debated during the 111th Congress. For example, "America's Affordable Health Choices Act of 2009" (H.R. 3200) was introduced in the House of Representatives on July 14, 2009. Like the Act, it contained an individual mandate and concomitant penalty. However, it called the penalty a tax. Section 401 was unambiguously titled "Tax on Individuals Without Acceptable Health Care Coverage," and went on to refer to the exaction as a "tax" no less than fourteen times in that section alone. *See, e.g., id.* (providing that with respect to "any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax"). H.R. 3200 was thereafter superseded by a similar bill, "Affordable Health Care for America Act" (H.R. 3962), which was actually passed in the House of Representatives on November 7, 2009. That second House bill also included an individual mandate and penalty, and it repeatedly referred to the penalty as a "tax." *See, e.g.*, Section 501 (providing that for any person who does not comply with the individual mandate "there is hereby imposed a tax," and referring to that "tax" multiple times); Section 307(c)(1)(A) (further referring to the

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Obama: Requiring Health Insurance is Not a Tax Increase, CNN, Sept. 29, 2009, available at: http://www.cnn.com/2009/POLITICS/09/20/obama.health.care/index.html.

penalty as a "tax[ ] on individuals not obtaining acceptable coverage").

While the above bills were being considered in the House, the Senate was working on its healthcare reform bills as well. On October 13, 2009, the Senate Finance Committee passed a bill, "America's Healthy Future Act" (S. 1796). A precursor to the Act, this bill contained an individual mandate and accompanying penalty. In the section titled "Excise Tax on Individuals Without Essential Health Benefits Coverage," the penalty was called a "tax." *See* Section 1301 ("If an applicable individual fails to [obtain required insurance] there is hereby imposed a tax").

In contrast to the foregoing, the Act — which was the final version of the healthcare legislation later passed by the Senate on December 24, 2009 — did *not* call the failure to comply with the individual mandate a tax; it was instead called a "penalty." The Act reads in pertinent part: "If an applicable individual fails to meet the requirement of subsection (a) . . . there is hereby imposed a penalty." Act § 1501(b)(1). Congress's conspicuous decision to not use the term "tax" in the Act when referring to the exaction (as it had done in at least three earlier incarnations of the legislation) is significant. "'Few principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded in favor of other language.'" *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442, 107 S. Ct. 1207, 94 L. Ed. 2d 434 (1987). Thus, "[w]here Congress includes [certain] language in an earlier version of a bill but deletes it prior to enactment, it may be presumed that the [omitted text] was not intended." *Russello v. United States*, 464 U.S. 16, 23-24, 104 S. Ct. 296, 78 L. Ed. 2d 17 (1983); *see also United States v. NEC Corp.*, 931 F.2d 1493, 1502 (11th Cir. 1991) (changes in statutory language "generally indicate[ ] an intent to change the meaning of the statute"); *Southern Pac. Transportation Co. v. Usery*, 539 F.2d 386, 390-91 (5th Cir. 1976) (rejecting the interpretation of a statute that was based on language in an earlier House version that the Senate changed prior to passing into law, and attaching "weight to the [Senate's] conscious and deliberate substitution of [the House's] language") (binding under *Bonner v. City of Prichard, Alabama*, 661 F.2d 1206, 1207 (11th Cir. 1981) (*en banc*)).

Congress's failure to call the penalty a "tax" is especially significant in light of the fact that the Act itself imposes a number of taxes in several other sections (*see, e.g.*, Excise Tax on Medical Device Manufacturers, § 1405 ("There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a tax"); Excise Tax on High Cost Employer-Sponsored Health Coverage, § 9001 ("there is hereby imposed a tax"); Additional Hospital Insurance Tax on High-Income Taxpayers, § 9015 ("there is hereby imposed a tax"); Excise Tax on Indoor Tanning Services, § 10907 ("There is hereby imposed on any indoor tanning service a tax")). This shows beyond question that Congress knew how to impose a tax when it meant to do so. Therefore, the strong inference and presumption must be that Congress did not intend for the "penalty" to be a tax. *See* generally *Hodge v.*

Muscatine County, 196 U.S. 276, 25 S. Ct. 237, 49 L. Ed. 477 (1905) (noting that "[i]t is not easy to draw an exact line of demarcation between a tax and a penalty," but where the statute uses "tax" in one section and "penalty" in another, courts "cannot go far afield" in treating the exaction as it is called; to do otherwise "would be a distortion of the words employed"); *see also Duncan v. Walker*, 533 U.S. 167, 173, 121 S. Ct. 2120, 150 L. Ed. 2d 251 (2001) ("It is well settled that '[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.'") (citations omitted); *Freemanville Water Sys., Inc. v. Poarch Band of Creek Indians*, 563 F.3d 1205, 1209 (11th Cir. 2009) ("[W]here Congress knows how to say something but chooses not to, its silence is controlling"); *DIRECTV, Inc. v. Brown*, 371 F.3d 814, 818 (11th Cir. 2004) ("[W]hen Congress uses different language in similar sections, it intends different meanings.").

The defendants assert in their memorandum, *see* Memorandum in Support of Defendants' Motion to Dismiss ("Def. Mem."), at 33, 50 n.23 (doc. 56-1), as they did during oral argument, that in deciding whether the exaction is a penalty or tax, "it doesn't matter" what Congress called it because the label "is not conclusive." *See* Transcript of Oral Argument ("Tr."), at 27-29 (doc. 77). As a general rule, it is true that the label used is not controlling or dispositive because Congress, at times, may be unclear and use inartful or ambiguous language. Therefore, as the Supreme Court recognized more than 100 years ago in *Helwig, supra*, the use of a particular word "does not change the nature and character of the [exaction]," and it is the ultimate duty of the court to decide the issue based on "the intrinsic nature of the provision" irrespective of what it is called. *See* 188 U.S. at 612-13; *accord Cooley v. Bd. of Wardens*, 53 U.S. (12 How.) 299, 314, 13 L. Ed. 996 (1851) ("it is the thing, and not the name, which is to be considered"). However, as also noted in *Helwig*, this rule must be set aside when it is clear and manifest that Congress intended the exaction to be regarded as one and not the other. For that reason, the defendants are wrong to contend that what Congress called it "doesn't matter." To the extent that the label used is not just a label, but is actually indicative of legislative purpose and intent, it very much does matter. By deliberately changing the characterization of the exaction from a "tax" to a "penalty," but at the same time including many other "taxes" in the Act, it is manifestly clear that Congress intended it to be a penalty and not a tax.[6]

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[6] A hypothetical helps to further illustrate this point. Suppose that after the Act imposed the penalty it went on to expressly state: "This penalty is not a tax." According to the logic of the defendants' argument, if the intrinsic nature of the penalty was a tax, it could still be regarded as one despite what it was called and despite the clear and unmistakable Congressional intent to the contrary. Such an outcome would be absurd. In my view, changing the word from tax to penalty, but at the same time including various other true (and accurately characterized) taxes in the Act, is the equivalent of Congress saying "This penalty is not a tax."

Quoting the Third Circuit in *Penn Mut. Indem. Co. v. C.I.R*, 277 F.2d 16, 20 (3d Cir. 1960), the defendants maintain that "'Congress has the power to impose taxes generally, and if the particular imposition does not run afoul of any constitutional restrictions then the tax is lawful, call it what you will.'" Def. Mem. at 50 n.23. I do not necessarily disagree with this position, at least not when it is quite clear that Congress intends to impose a tax and is acting pursuant to its taxing power. However, as will be discussed in the next section, that is not the situation here. In the *Penn Mutual Indemnity* case, for example, it was clear and undisputed that Congress had exercised its taxing authority to impose the exaction; it was inarguably a "tax," and the only question was whether it was an excise tax, an income tax, or some other type of tax. It was in that particular context that the Third Circuit's analysis included the quoted statement, and further elaborated that: "It is not necessary to uphold the validity of the tax imposed by the United States that the tax itself bear an accurate label." *See* 277 F.2d at 20. That is obviously a very different situation from the one presented here, where the precise label of an acknowledged tax is not being disputed, but rather whether it is even a tax at all.

(4) Congress did not state that it was acting under its taxing authority, and, in fact, it treated the penalty differently than traditional taxes

Congress did not state in the Act that it was exercising its taxing authority to impose the individual mandate and penalty; instead, it relied exclusively on its power under the Commerce

Clause. U.S. Const. art I, § 8, cl. 3 ("[Congress shall have Power] To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes"). The Act recites numerous (and detailed) factual findings to show that the individual mandate regulates commercial activity important to the economy. Specifically, it states that: "The [individual mandate] is commercial and economic in nature, and substantially affects interstate commerce" in that, *inter alia*, "[h]ealth insurance and health care services are a significant part of the national economy" and the mandate "will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services." Act § 1501(a)(1)-(2)(B)(C). It further states that health insurance "is in interstate commerce," and the individual mandate is "essential to creating effective health insurance markets." *Id.* § 1501(a)(2)(F), (H). The Act contains no indication that Congress was exercising its taxing authority or that it meant for the penalty to be regarded as a tax. Although the penalty is to be placed in the Internal Revenue Code under the heading "Miscellaneous Excise Taxes," the plain language of the Code itself states that this does not give rise to any inference or presumption that it was intended to be a tax. *See United States v. Reorganized CF&I Fabricators of Utah, Inc.*, 518 U.S. 213, 222-23, 116 S. Ct. 2106, 135 L. Ed. 2d 506 (1996) (citing to 26 U.S.C. § 7806(b), which provides that: "No inference, implication, or presumption of legislative construction shall be drawn or made by reason of the location or grouping of any particular section or provision or portion of this title"). In fact, while the penalty is placed under the "Excise Taxes" heading of the Code, at the same time Congress specifically exempted and divorced the penalty from all the traditional enforcement and collection methods used by the Internal Revenue Service, such as tax liens, levies, and criminal proceedings. *See* Act § 1501(b). These exemptions from normal tax attributes — coupled with Congress's failure to identify its taxing authority — belie the claim that, simply because it is mentioned in the Internal Revenue Code, the penalty must be a tax.[7]

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[7] In highlighting that Congress did not identify its taxing power as the basis for imposing the "penalty," I am not suggesting that legislative action is invalid if a power source is not identified. To the contrary, I recognize that "Congress's failure to cite [a particular power] does not eliminate the possibility that [said power] can sustain this legislation." *United States v. Moghadam*, 175 F.3d 1269, 1275 n.10 (11th Cir. 1999); *see also Wilson-Jones v. Caviness*, 99 F.3d 203, 208 (6th Cir. 1996) ("A source of power [can] justify an act of Congress even if Congress did not state that it rested the act on the particular source of power.") (citing cases, including *Woods v. Cloyd W. Miller Co.*, 333 U.S. 138, 144, 68 S. Ct. 421, 92 L. Ed. 596 (1948) ("The question of the constitutionality of action taken by Congress does not depend on recitals of the power which it undertakes to exercise.")). Thus, to be clear, I am not saying that the penalty is invalid as a tax because Congress did not expressly identify its taxing power. Rather, its failure to do so (particularly when it took time to extensively identify its Commerce Clause power), is merely one of several facts that shows Congress was not exercising its taxing authority and did not intend for the penalty to be regarded as a tax.

(5) Lack of statutorily-identified revenue-generating purpose

Perhaps most significantly, the Act does not mention any revenue-generating purpose that is to be served by the individual mandate penalty, even though such a purpose is required. *See Rosenberger v. Rector and Visitors of Univ. of Virginia*, 515 U.S. 819, 841, 115 S. Ct. 2510, 132 L. Ed. 2d 700 (1995) ("'A tax, in the general understanding of the term, and as used in the Constitution, signifies an exaction for the support of the Government'"). In this circuit, the ultimate test of tax validity "is whether *on its face* the tax operates as a revenue generating measure and the attendant regulations are in aid of a revenue purpose." *United States v. Ross*, 458 F.2d 1144, 1145 (5th Cir. 1972) (emphasis added) (binding under *Bonner, supra*, 661 F.2d at 1207).

The revenue-generating provisions in the Act were an important part of the legislation as they were necessary under current Congressional procedure to score its final cost. To be sure, much of the debate within and outside Congress focused on the bill's final price tag and whether it would exceed the threshold of $1 trillion over the course of the first ten years; and while the legislation was being debated, Congress worked closely and often with the Congressional Budget Office ("CBO") to ensure that it did not. Obviously, if the penalty had been intended by Congress to be a true revenue-generating tax (that could be used to keep the Act's final cost down) then it would have been treated as a tax "on its face." During oral argument, defense counsel stated that "[t]he purpose of the [penalty] is . . . to raise revenue to offset expenditures of the federal government that it makes in connection, for example, with the Medicaid expansion." *See* Tr. at 9. However, there is absolutely no support for that statement in the statute itself.

On its face, the Act lists seventeen "Revenue Offset Provisions" (including the several taxes described *supra*), and, as reconciled, it further includes a section entitled "Provisions Relating to Revenue" (which also references those taxes and other revenue offsetting provisions). However, the individual mandate penalty is not listed anywhere among them. Nowhere in the statute is the penalty provision identified or even mentioned as raising revenue and offsetting the Act's costs. It is especially noteworthy that the Act does not identify revenue to be generated from the penalty (which the defendants now maintain would raise about $*4 billion* each year), but the statute identifies the tanning salon tax as revenue-raising (even though that tax is expected to raise a significantly smaller *$300 million* annually). *See* Joint Committee on Taxation, Estimated Revenue Effects of the Manager's Amendment to the Revenue Provisions Contained in the "Patient Protection and Affordable Care Act," as Passed by the Senate on December 24, 2009 (JCX-10-10), March 11, 2010, at 2. If Congress had intended and understood the penalty to be a tax that would raise revenue for the government, which could in turn be used to partially finance the Act's budgetary effect and help keep its ten-year cost below the $1 trillion threshold by offsetting its expenditures, it makes little sense that Congress would ignore a "tax" that could be expected to raise almost $20 billion in revenue between the years

2015-2019, yet mention another tax that was expected to raise less than one-tenth of that revenue annually during the same time period.

To the extent there is statutory ambiguity on this issue, both sides ask that I look to the Act's legislative history to determine if Congress intended the penalty to be a tax. Ironically, they rely on the same piece of legislative history in making their respective arguments, to wit, the 157-page "Technical Explanation" of the Act that was prepared by the Staff of the Joint Committee on Taxation on March 21, 2010 (the same day the House voted to approve and accept the Senate bill and two days before the bill was signed into law). The plaintiffs highlight the fact that the report "consistently" refers to the penalty as a penalty and *not* a tax, *see* Pl. Mem. at 19 (as compared, for example, with the tanning salon tax that is consistently referred to as a "tax" in that same report, *see* JCT, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in Combination with the "Patient Protection and Affordable Care Act" (JCX-18-10), March 21, 2010, at 108). The defendants, on the other hand, highlight the fact that the JCT referred to the penalty as an "excise tax" in a single heading in that report. *See* Def. Mem. At 51.

As the Supreme Court has repeatedly held, "the authoritative statement is the statutory text, not the legislative history or any other extrinsic material. Extrinsic materials have a role in statutory interpretation *only* to the extent they shed a reliable light on the enacting Legislature's understanding of otherwise *ambiguous terms*." *Exxon Mobil Corp. v.*

Allapattah Services, Inc., 545 U.S. 546, 568, 125 S. Ct. 2611, 162 L. Ed. 2d 502 (2005) (emphasis added). On the facts of this case, "penalty" is not an ambiguous term, but rather was a carefully and intentionally selected word that has a specific meaning and carries a particular import (discussed *infra*). Moreover, even if the term was ambiguous, the Supreme Court has pointed out two "serious criticisms" of attempting to rely on legislative history:

> Not all extrinsic materials are reliable sources of insight into legislative understandings . . ., and legislative history in particular is vulnerable to two serious criticisms. First, legislative history is itself often murky, ambiguous, and contradictory. Judicial investigation of legislative history has a tendency to become, to borrow Judge Leventhal's memorable phrase, an exercise in "'looking over a crowd and picking out your friends.'" *See* Wald, Some Observations on the Use of Legislative History in the 1981 Supreme Court Term, 68 Iowa L. Rev. 195, 214 (1983). Second, judicial reliance on legislative materials like committee reports, which are not themselves subject to the requirements of Article I, may give unrepresentative committee members — or, worse yet, unelected staffers and lobbyists — both the power and the incentive to attempt strategic manipulations of legislative history to secure results they were unable to achieve through the statutory text. *Id.*

In this case, both criticisms are directly on the mark. The report is ambiguous and contradictory, as evidenced by the simple fact that both sides claim it supports their position. Should I look to the heading (that calls the exaction an "excise tax"), or should I look to the actual body of the report (that calls it a penalty no less than twenty times with no mention of it being a tax)? It is, as Judge Leventhal said, like "looking over a crowd and picking out your friends." Further, a strong argument could be (and has been) made that the staffers who drafted the report were merely engaging in last minute "strategic manipulation" to secure results they were unable to achieve through the Act itself. *See, e.g., The Insurance Mandate in Peril*, Wall St. J., Apr. 29, 2010, at A19 (opining that the "excise tax" heading in the JCT report should not be used to convert the penalty into a tax because the Supreme Court "will not allow staffers and lawyers to change the statutory cards that Congress already dealt when I adopted the Senate language"). For these reasons, as recognized by the Supreme Court, resort to, or reliance upon, the JCT staff's Technical Explanation would be inappropriate on the facts of this case — even if the term "penalty" was ambiguous (which it is not).

To summarize the foregoing, it "clearly appears" from the statute itself, *see Helwig, supra*, 188 U.S. 613, that Congress did not intend to impose a tax when it imposed the penalty. To hold otherwise would require me to look beyond the plain words of the statute. I would have to ignore that Congress:

(i) specifically changed the term in previous incarnations of the statute from "tax" to "penalty;"

(ii) used the term "tax" in describing the several other exactions provided for in the Act;

(iii) specifically relied on and identified its Commerce Clause power and not its taxing power;

(iv) eliminated traditional IRS enforcement methods for the failure to pay the "tax;" and

(v) failed to identify in the legislation any revenue that would be raised from it, notwithstanding that at least seventeen other revenue-generating provisions were specifically so identified.

The defendants have not pointed to any reported case decided by any court of record that has ever found and sustained a tax in a situation such as the one presented here, and my independent research has also revealed none. At bottom, the defendants are asking that I divine hidden and unstated intentions, and despite considerable evidence to the contrary, conclude that Congress really meant to say one thing when it expressly said something else. The Supreme Court confronted the inverse of this situation in *Sonzinsky, supra,* and I believe the rationale of that case forecloses the defendants' argument.

The issue in *Sonzinsky* was whether a levy on the sale of firearms was a tax. The exaction was called a tax on its face, and it was undisputed that it had been passed pursuant to Congress's taxing power. Nonetheless, the petitioner sought to invalidate the tax because it was "prohibitive in effect and [disclosed] unmistakably the legislative purpose to regulate rather than to tax." The petitioner argued that it was not "a true tax, but a penalty." In rejecting this argument, the Supreme Court explained:

> Inquiry into the hidden motives which may move Congress to exercise a power constitutionally conferred upon it is beyond the competency of courts. They will not undertake, by collateral inquiry as to the measure of the regulatory effect of a tax, to ascribe to Congress an attempt, under the guise of taxation, to exercise another power.

Stated somewhat differently, reviewing courts cannot look beyond a statute and inquire as to whether Congress meant something different than what it said. If an exaction says "tax" on its face and was imposed pursuant to Congress's taxing power, courts "are not free to speculate as to the motives which moved Congress to impose it, or as to the extent to which it may [be a penalty intended] to restrict the activities taxed." *See generally Sonzinsky, supra*, 300 U.S. at 511-14; *accord Kahriger, supra*, 345 U.S. at 22 (similarly declining invitation to hold that "under the pretense of exercising" a particular power, Congress was, in fact, exercising another power).

The holding of *Sonzinsky* cuts both ways, and applying that holding to the facts here, I have no choice but to find that the penalty is not a tax. Because it is called a penalty on its face (and because Congress knew how to say "tax" when it intended to, and for all the other reasons noted), it would be improper to inquire as to whether Congress really meant to impose a tax. I will not assume that

Congress had an unstated design to act pursuant to its taxing authority, nor will I impute a revenue-generating purpose to the penalty when Congress specifically chose not to provide one. It is "beyond the competency" of this court to question and ascertain whether Congress really meant to do and say something other than what it did. As the Supreme Court held by necessary implication, this court cannot "undertake, by collateral inquiry as to the measure of the [revenue-raising] effect of a [penalty], to ascribe to Congress an attempt, under the guise of [the Commerce Clause], to exercise another power." *See Sonzinsky, supra,* 300 U.S. at 514. This conclusion is further justified in this case since President Obama, who signed the bill into law, has "absolutely" rejected the argument that the penalty is a tax. *See supra* note 5.

To conclude, as I do, that Congress imposed a penalty and not a tax is not merely formalistic hair-splitting. There are clear, important, and well-established differences between the two. *See Dep't of Revenue of Montana v. Kurth Ranch,* 511 U.S. 767, 779-80, 114 S. Ct. 1937, 128 L. Ed. 2d 767 (1994) ("Whereas [penalties] are readily characterized as sanctions, taxes are typically different because they are usually motivated by revenue-raising, rather than punitive, purposes."); *Reorganized CF&I Fabricators of Utah, Inc., supra,* 518 U.S. at 224 ("'a tax is a pecuniary burden laid upon individuals or property for the purpose of supporting the Government,'" whereas, "if the concept of penalty means anything, it means punishment for an unlawful act or omission"); *United States v. La Franca,* 282 U.S. 568, 572, 51 S. Ct. 278, 75 L. Ed.

551 (1931) ("A 'tax' is an enforced contribution to provide for the support of government; a 'penalty,' as the word is here used, is an exaction imposed by statute as punishment for an unlawful act.'"). Thus, as the Supreme Court has said, "[t]he two words are not interchangeable one for the other . . . ; and if an exaction be clearly a penalty it cannot be converted into a tax by the simple expedient of calling it such." *La Franca, supra*, 282 U.S. at 572.

(6) Does the Anti-Injunction Act apply anyway?

The defendants insist that the Anti-Injunction Act should still preclude the individual mandate challenges even if the penalty is not a tax. For this argument, the defendants rely on Title 26, United States Code, Section 6671, which states that the "penalties" provided under subchapter B of chapter 68 of the IRS Code (a classification that includes the individual mandate penalty) "shall be assessed and collected in the same manner as taxes." If the penalty is intended to be assessed and collected in the same manner as a tax, the defendants contend, then the Anti- Injunction Act should apply. I do not agree. First of all, the penalty is obviously *not* to be collected and treated "in the same manner as taxes" in light of the fact that Congress specifically divorced the penalty from the tax code's traditional collection and enforcement mechanisms. Further, and more significantly, as noted *supra*, the whole point of the Anti-Injunction Act is to protect the government in the collection of its lawful tax revenues, and thus it applies to "truly revenue-raising tax statutes," which Congress plainly did not understand and intend the penalty to be. The Eleventh Circuit has recognized (albeit by implication) that the Anti-Injunction Act does not reach penalties that are, as here, "imposed for substantive violations of laws not directly related to the tax code" and which are not good-faith efforts to enforce the technical requirements of the tax law. *Cf. Mobile Republican Assembly v. United States*, 353 F.3d 1357, 1362 n.5 (11th Cir. 2003). The defendants have cited two out-of-circuit cases in support of their contention that Section 6671(a) requires penalties to be treated the same as taxes for Anti-Injunction Act purposes, *Barr v. United States*, 736 F.2d 1134 (7th Cir. 1984); *Warren v. United States*, 874 F.2d 280 (5th Cir. 1989). Although those cases did indeed hold that the penalties at issue fell under the Anti-Injunction Act, they do not really support the defendants' position. As the plaintiffs note, the penalties in both those cases were imposed for failing to pay an undisputed *tax*, that is, falsely claiming an exemption in *Barr*, and refusing to sign a tax return in *Warren*. In other words, the penalties were "directly related to the tax code." *Cf. Mobile Republican Assembly, supra*, 353 F.3d at 1362 n.5. Allowing IRS penalties such as those to qualify as a tax for Anti-Injunction Act purposes "is simply a means for ensuring that the [underlying] tax is paid." *See Botta v. Scanlon*, 314 F.2d 392, 393 (2d Cir. 1963). That is not the situation here. It would be inappropriate to give tax treatment under the Anti-Injunction Act to a civil penalty that, by its own terms, is not a tax; is not to be enforced as a tax; and does not bear any meaningful relationship to the revenue-generating purpose of the tax code. Merely placing a penalty (which virtually all federal statutes have) in the IRS Code, even though it otherwise bears no meaningful relationship thereto, is not enough to render the Anti-Injunction Act (which only applies to true revenue-raising exactions) applicable to this case.

(7) Accountability

I will say one final thing on the tax issue, which, although I believe it to be important, is not essential to my decision. For purposes of this discussion, I will assume that the defendants are correct and that the penalty is (and was always intended to be) a tax.

In *Virginia v. Sebelius*, 3:10cv188, one of the twenty or so other lawsuits challenging the Act, the federal government's lead counsel (who is lead defense counsel in this litigation, as well) urged during oral argument in that case that the penalty is proper and sustainable under the taxing power. Although that power is broad and does not easily lend itself to judicial review, counsel stated, "there is a check. It's called Congress. *And taxes are scrutinized*. And the reason we don't have all sorts of crazy taxes is because taxes are among the *most scrutinized* things we have. *And the elected representatives in Congress are held accountable for taxes that they impose.*" *See* Transcript of Oral Argument (Virginia case), at 45 (emphasis added).

This foregoing statement highlights one of the more troubling aspects of the defendants' "newfound"[8] tax argument. As noted at the outset of this order, and as anyone who paid attention to the healthcare reform debate already knew, the Act was very controversial at the time of passage. Irrespective of the merits of the arguments for or against it, the legislation required lawmakers in favor of the bill to cast politically difficult and tough votes. As it turned out, the voting was extremely close. Because by far the most publicized and controversial part of the Act was the individual mandate and penalty, it would no doubt have been even more difficult to pass the penalty as a tax. Not only are taxes always unpopular, but to do so at that time would have arguably violated pledges by politicians (including the President) to not raise taxes, which could have made it that much more difficult to secure the necessary votes for passage. One could reasonably infer that Congress proceeded as it did specifically *because* it did not want the penalty to be "scrutinized" as a $4 billion annual tax increase, and it did not want at that time to be "held accountable for taxes that they imposed." In other words, to the extent that the defendants are correct and the penalty was intended to be a tax, it seems likely that the members of Congress merely called it a penalty and did not describe it as revenue-generating to try and insulate themselves from the potential electoral ramifications of their votes.

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[8] *See, e.g., Changing Stance, Administration Now Defends Insurance Mandate as a Tax*, N.Y. Times, July 17, 2010, at A14 ("When Congress required most Americans to obtain health

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insurance or pay a penalty, Democrats denied that they were creating a new tax. But in court, the Obama administration and its allies now defend the requirement as an exercise of the government's 'power to lay and collect taxes.'").

Regardless of whether the members of Congress had this specific motivation and intent (which, once again, is not my place to say), it is obvious that Congress did not pass the penalty, in the version of the legislation that is now "the Act," as a tax under its taxing authority, but rather as a penalty pursuant to its Commerce Clause power. Those two exactions, as previously noted, are not interchangeable. And, now that it has passed into law on that basis, government attorneys have come into this court and argued that it was a tax after all. This rather significant shift in position, if permitted, could have the consequence of allowing Congress to avoid the very same accountability that was identified by the government's counsel in the Virginia case as a check on Congress's broad taxing power in the first place. In other words, the members of Congress would have reaped a *political advantage* by calling and treating it as a penalty while the Act was being debated, *see Virginia v. Sebelius*, 702 F. Supp. 2d 598, 612 (E.D. Va. 2010) (referring to "preenactment representations by the Executive and Legislative branches" that the penalty was *not* "a product of the government's power to tax for the general welfare"), and then reap a *legal advantage* by calling it a tax in court once it passed into law. *See* Def. Mem. at 33-34, 49 (arguing that the Anti-Injunction Act bars any challenge to the penalty which, in any event, falls under Congress's "very extensive" authority to tax for the general welfare). This should not be allowed, and I am not aware of any reported case where it ever has been.

Congress should not be permitted to secure and cast politically difficult votes on controversial legislation by deliberately calling something one thing, after which the defenders of that legislation take an "Alice-in-Wonderland" tack[9] and argue in court that Congress really meant something else entirely, thereby circumventing the safeguard that exists to keep their broad power in check. If Congress intended for the penalty to be a tax, it should go back and make that intent clear (for example, by calling it a tax, relying on Congress's Constitutional taxing power, allowing it to be collected and enforced as a tax, or identifying revenue to be raised) so it can be "scrutinized" as a tax and Congress can accordingly be held accountable. They cannot, however, use a different linguistic with a perhaps secret understanding between themselves that the word, in fact, means something else entirely. As the First Circuit has explained, the integrity of the process must be guaranteed by the judiciary:

> In our republican form of government, legislators make laws by writing statutes — an exercise that requires putting words on paper in a way that conveys a reasonably definite meaning. Once Congress has spoken, it is bound by what it has plainly said, notwithstanding the nods and winks

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[9] Lewis, Carroll, *Through the Looking-Glass*, Chapter 6 (Heritage 1969):

> "When I use a word," Humpty Dumpty said, in a rather scornful tone, "it means just what I choose it to mean — neither more or less."

> "The question is," said Alice, "whether you *can* make words mean so many different things."

> that may have been exchanged. . . . And the judiciary must stand as the ultimate guarantor of the integrity of an enacted statute's text.

State of Rhode Island v. Narragansett Indian Tribe, 19 F.3d 685, 699-70 (1st Cir. 1994).

(8) For Constitutional purposes, it is a penalty, and must be analyzed under Congress's Commerce Clause power

For all the above reasons, I conclude that the individual mandate penalty is not a "tax." It is (as the Act itself says) a penalty. The defendants may not rely on Congress's taxing authority under the General Welfare Clause to try and justify the penalty after-the-fact. If it is to be sustained, it must be sustained as a penalty imposed in aid of an enumerated power, to wit, the Commerce Clause power. *See Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 393, 60 S. Ct. 907, 84 L. Ed. 1263 (1940) ("Congress may impose penalties in aid of the exercise of any of its enumerated powers"). Therefore, the Anti-Injunction Act does not deprive this court of jurisdiction. *See Lipke, supra*, 259 U.S. at 562 ("The collector demanded payment of a penalty, and [thus the Anti-Injunction Act], which prohibits suits to restrain assessment or collection of any tax, is without application."). I will next consider the rest of the defendants' jurisdictional challenges.

B. Rule 12(b)(1) ("Lack of Subject Matter Jurisdiction") Challenges

The defendants raise two additional jurisdictional arguments: first, that the individual plaintiffs and the NFIB do not have standing to pursue Counts

One and Two, and the state plaintiffs do not have standing with respect to Count Six; and second, that those same causes of action are not ripe.

(1) Standing

The Constitution limits the subject matter of the federal courts to "cases" and "controversies." U.S. Const. art III, § 2. "[T]he core component of standing is an essential and unchanging part of the case-or-controversy requirement of Article III." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S. Ct. 2130, 119 L. Ed. 2d 351 (1992). The "irreducible constitutional minimum of standing" contains three elements: "(1) an injury in fact, meaning an injury that is concrete and particularized, and actual or imminent, (2) a causal connection between the injury and the causal conduct, and (3) a likelihood that the injury will be redressed by a favorable decision." *Granite State Outdoor Advertising Inc. v. City of Clearwater*, 351 F.3d 1112, 1116 (11th Cir. 2003). The defendants appear to concede that (2) and (3) are present in this litigation, but contend that the plaintiffs cannot establish an injury-in-fact. Accordingly, only element (1) is at issue here.

For purposes of ruling on the defendants' motion to dismiss, I simply need to examine the plaintiffs' factual allegations:

> At the pleading stage, general factual allegations of injury resulting from defendant's conduct may suffice, for on a motion to dismiss we "presum[e] that general allegations embrace those specific facts that are necessary to support the claim."

Lujan, supra, 504 U.S. at 561 (quoting *Lujan v. Nat'l Wildlife Federation*, 497 U.S. 871, 889, 110 S. Ct. 3177, 111 L. Ed. 2d 695 (1990)). Thus, "mere allegations of injury" are sufficient to withstand a motion to dismiss based on lack of standing. *Dep't of Commerce v. U.S. House of Representatives*, 525 U.S. 316, 329, 119 S. Ct. 765, 142 L. Ed. 2d 797 (1999); *accord Miccosukee Tribe of Indians of Florida v. Southern Everglades Restoration Alliance*, 304 F.3d 1076, 1081 (11th Cir. 2002) (noting "at the motion to dismiss stage [the plaintiff] is only required to generally allege a redressable injury caused by the actions of [the defendant] about which it complains").

The individual plaintiffs make numerous allegations in the amended complaint that are relevant to the standing issue. According to those allegations, Mary Brown is a small business owner and current member of the NFIB. She has not had health insurance for the last four years. She devotes her available resources to maintaining her business and paying her employees. She does not currently qualify for Medicaid or Medicare, and she does not expect to qualify for those programs prior to the individual mandate taking effect. Thus, "Ms. Brown will be subject to the mandate and objects to being forced to comply with it" because, *inter alia*, it will force her (and other NFIB members) "to divert resources from their business endeavors" and "reorder their economic circumstances" to obtain qualifying coverage. Similarly, Kaj Ahlburg has not had health insurance for more than six years; he has no intention or desire to get health insurance; he does not qualify for Medicaid or Medicare and will thus be subject to the individual mandate and penalty; and he is, and expects to remain, financially able to pay for his own healthcare services if and as needed. The individual plaintiffs object to the Act's "unconstitutional overreaching" and claim injury because the individual mandate will force them to spend their money to buy something they do not want or need (or be penalized). *See* Am. Compl. ¶¶ 27- 28, 62. The defendants make several arguments why these claims are insufficient to establish an injury-in-fact.

First, quoting *Lujan, supra,* the defendants contend that "[a] plaintiff alleging 'only an injury at some indefinite future time' has not shown injury in fact." Def. Mem. at 26. While that statement is certainly true, the injury alleged in this case will not occur at "some indefinite future time." Instead, the date is definitively fixed in the Act and will occur in 2014, when the individual mandate goes into effect and the individual plaintiffs are forced to buy insurance or pay the penalty. *See ACLU of Florida, Inc. v. Miami-Dade County School Bd.*, 557 F.3d 1177, 1194 (11th Cir. 2009) (standing shown in pre-enforcement challenge where the claimed injury was "pegged to a sufficiently fixed period of time"). Because time is the primary factor here, this case presents a durational issue, and not a contingency issue. "A plaintiff who challenges a statute must demonstrate a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement. But, 'one does not have to await the consummation of threatened injury to obtain preventive relief. If the injury is certainly impending, that is enough.'" *Babbitt v. United Farm*

Workers Nat'l Union, 442 U.S. 289, 298, 99 S. Ct. 2301, 60 L. Ed. 2d 895 (1979) (citations and brackets omitted). The defendants contend that the forty-months gap between now and 2014 is "too far off" and not immediate enough to confer standing. However, as the Eleventh Circuit has expressly held:

> [P]laintiffs here have alleged when and in what manner the alleged injuries are likely going to occur. Immediacy requires only that the anticipated injury occur with some fixed period of time in the future, not that it happen in the colloquial sense of soon or precisely within a certain number of days, weeks, or months.

Fla. State Conf. of the NAACP v. Browning, 522 F.3d 1153, 1161 (11th Cir. 2008) (citing *Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 115 S. Ct. 2097, 132 L. Ed. 2d 158 (1995)); *accord 520 Michigan Ave. Associates, Ltd. v. Devine*, 433 F.3d 961, 962 (7th Cir. 2006) ("Standing depends on the probability of harm, not its temporal proximity. When injury . . . is likely in the future, the fact that [the complained of harm] may be deferred does not prevent federal litigation now.").

The defendants concede that an injury does not have to occur immediately to qualify as an injury-in-fact, but they argue that forty months "is far longer than typically allowed." Def. Mem. at 27. It is true that forty months is longer than the time period at issue in the particular cases the defendants cite. *See, e.g., ACLU, supra*, 557 F.3d at 1194 (harm was six weeks away); *Nat'l Parks Conservation Ass'n v. Norton*, 324 F.3d 1229, 1242 (11th Cir. 2003) (harm was between one week to one month away). But, the fact that the harm was closer in those cases does not necessarily mean that forty months is ipso facto "too far off." In *Village of Bensenville v. FAA*, 376 F.3d 1114 (D.C. Cir. 2004), for example, the plaintiffs challenged a passenger fee at Chicago's O'Hare International Airport that was not scheduled to be imposed until *thirteen years* in the future. The District of Columbia Circuit held that, despite the significant time gap, there was an "'impending threat of injury'" to plaintiffs that was "'sufficiently real to constitute injury-in-fact and afford constitutional standing'" because the decision to impose the fee was "final and, absent action by us, come 2017 Chicago will begin collecting [it]." *See id.* at 1119 (citations omitted). That is the same situation at issue here. Imposition of the individual mandate and penalty, like the fee in *Village of Bensenville*, is definitively fixed in time and impending. And absent action by this court, starting in 2014, the federal government will begin enforcing it.

The defendants suggest that the individual plaintiffs may not have to be forced to comply with the individual mandate in 2014. They contend that the individual plaintiffs "cannot reliably predict that insurance will be an economic burden" to them when the individual mandate is in place because, once the Act "mak[es] health insurance more affordable," they may decide to voluntarily buy insurance on their own. Def. Mem. at 26. This argument appears to presuppose that the individual plaintiffs object to the individual mandate solely on the grounds that it will be an "economic burden" to them, and that they do not currently have insurance because they cannot afford it. That does not appear to be the case. Ms. Brown alleges in the amended complaint that she devotes her resources to running and maintaining her business and paying her employees; she does *not* allege that she has no money left over after doing so or that she is otherwise *unable* to buy insurance if she wanted it. Rather, she has apparently just made the decision that she would prefer to direct and divert her resources elsewhere because obtaining insurance, in her particular situation, is not "a worthwhile cost of doing business." *See* Am. Comp. ¶¶ 27, 62. Further, Mr. Ahlburg has affirmatively stated that he is financially able to pay for all of his own healthcare-related services. Thus, both he and Ms. Brown do not want to be forced to spend their money (whether they have a little or a lot) on something they do not want (or feel that they need), and, in this respect, they object to the individual mandate as "unconstitutional overreaching." *See* Am. Comp. at ¶¶ 27, 28.[10]

Continuing this argument, the defendants further contend that there is too much "uncertainty" surrounding the individual plaintiffs' allegations.

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[10] And in any event, the defendants' argument seems to assume that the Act will, in fact, reduce premiums so that insurance is "more affordable." That claim is both self-serving and far from undisputed. Indeed, most objective analyses indicate an insurance premium *increase*, and the CBO itself has predicted that premiums will rise 10-13% under the Act, at least with respect to individuals with certain policies who do not qualify for government subsidies. *See* Congressional Budget Office, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable

They allege, for example, that while Ms. Brown may not want to purchase healthcare insurance now (because she would rather devote her resources to her business), and although Mr. Ahlburg does not need insurance now (because he is financially able to pay for his own healthcare out-of-pocket and as needed), the "vagaries" of life could alter their situations by 2014. Def Mem. at 26. The defendants suggest that because "businesses fail, incomes fall, and disabilities occur," by the time the individual mandate is in effect, the individual plaintiffs "could find that they need insurance, or that it is the most sensible choice." *See id.* That is possible, of course. It is also "possible" that by 2014 either or both the plaintiffs will no longer be alive, or may at that time fall within one of the "exempt" categories. Such "vagaries" of life are always present, in almost every case that involves a pre-enforcement challenge. If the defendants' position were correct, then courts would essentially *never* be able to engage in pre-enforcement review. Indeed, it is easy to conjure up hypothetical events that could occur to moot a case or deprive any plaintiff of standing in the future. In *Pierce v. Society of Sisters*, 268 U.S. 510, 45 S. Ct. 571, 69 L. Ed. 2d 1070 (1925), for example, a private school sought and obtained review of a law that required children to attend public schools, even though that law was not to take effect for more than two years. Under the defendants' position, there was no standing to consider the case because — since "businesses fail" — it was possible that the school may have closed down by the time the law finally went into effect. However, the Supreme Court found that it had standing to consider the challenge, notwithstanding the universe of possibilities that could have occurred between the filing of the suit and the law going into effect years later. The Court concluded that it was appropriate to consider the challenge because the complained of injury "was present and very real, not a mere possibility in the remote future," and because the "[p]revention of impending injury by unlawful action is a well-recognized function of courts of equity." *Id.* at 536.

In short, to challenge the individual mandate, the individual plaintiffs need not show that their anticipated injury is absolutely certain to occur despite the "vagaries" of life; they need merely establish "a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement," *see Babbitt, supra*, 442 U.S. at 298, that is reasonably "pegged to a sufficiently fixed period of time," *see ACLU, supra*, 557 F.3d at 1194, and which is not "merely hypothetical or conjectural," *see NAACP, supra*, 522 F.3d at 1161. Based on the allegations in the amended complaint, I am satisfied that the individual plaintiffs have done so. Accordingly, they have standing to pursue Counts One and Two.

The defendants next contend that the state plaintiffs do not have standing to pursue the employer mandate being challenged in Count Six. They devote less than one paragraph to this argument, *see* Def. Mem. at 21, and I can be equally brief in addressing it. For this count, the state plaintiffs contend that in their capacities as "large employers," they will have to offer and enroll state employees in federally approved health plans, which they currently do not do. They claim, for example, that under existing Florida law, thousands of OPS (Other Personnel Services) employees are excluded from that state's healthcare plan, but under the Act the employees will have to be enrolled in an approved health plan, which will cost the state money if they do, and will cost the state money (in the form of penalties) if they do not. I am satisfied that this qualifies as an injury-in-fact, for essentially the same reasons discussed with respect to the individual mandate — to wit, the state plaintiffs have established a realistic (and not hypothetical or conjectural) danger of sustaining a redressable injury at a sufficiently fixed point in time as a result of the Act's operation or enforcement.

The individual plaintiffs thus have standing to pursue Counts One and Two, and the state plaintiffs have standing to pursue Count Six. Because those are the only causes of action for which the defendants have challenged standing, this eliminates any need to discuss whether the NFIB also has standing. *See Watt v. Energy Action Educational Foundation*, 454 U.S. 151, 160, 102 S. Ct. 205, 70 L. Ed. 2d 309 (1981) ("Because we find California has standing, we do not consider the standing of the other plaintiffs."); *Village of Arlington Heights v. Metropolitan Housing Dev. Corp.*, 429 U.S. 252, 264 n.9, 97 S. Ct. 555, 50 L. Ed. 2d 450 (1977) ("Because of the presence of this plaintiff, we need not consider whether the other individual and corporate plaintiffs have standing to maintain this suit."); *see also Mountain States Legal Found. v. Glickman*, 92 F.3d 1228, 1232 (D.C. Cir. 1996) ("For each [challenged] claim, if . . . standing can be shown for at least one plaintiff, we need not consider the standing of the other plaintiffs to raise that claim.") (citing *Watt* and *Village of Arlington Heights, supra*).

However, for the sake of completeness, I will briefly discuss whether the NFIB has standing as well. Under *Hunt v. Washington State Apple Advertising Comm'n*, 432 U.S. 333, 97 S. Ct. 2434, 53 L. Ed. 2d 383 (1977), an association has representative standing when "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Id.* at 343. All three elements have been satisfied here. First, the NFIB's members (including Ms. Brown, as noted) plainly have standing to challenge the individual mandate, thus meeting *Hunt's* first element. Furthermore, the interests that the NFIB seeks to protect in challenging the individual mandate on behalf of its members — certain of whom operate sole proprietorships and will suffer cost and cash flow consequences if they are compelled to buy qualifying healthcare insurance — are germane to the NFIB's purpose and mission "to promote and protect the rights of its members to own, operate, and earn success in their businesses, in accordance with lawfully imposed governmental requirements." Am. Comp. ¶ 26; *see, e.g., New York State Club Ass'n, Inc. v. City of New York*, 487 U.S. 1, 10 n.4, 108 S. Ct. 2225, 101 L. Ed. 2d 1 (1988) (consortium of private clubs had standing to sue on behalf of its members to enjoin state anti-discrimination law because the interests it sought to protect were "clearly" germane to its broad purpose "'to promote the common business interests of its [member clubs]'") (brackets in original). And lastly, because the NFIB seeks injunctive relief which, if granted, will benefit its individual members, joinder is generally not required. *See, e.g., NAACP, supra*, 522 F.3d at 1160 (*Hunt's* third element satisfied because, "when the relief sought is injunctive, individual participation of the organization's members is 'not normally necessary'") (citation omitted).

In light of the foregoing, the plaintiffs have standing to pursue their claims.

(2) Ripeness

There is a "conspicuous overlap" between the doctrines of standing and ripeness and the two "often converge[ ]." *See Elend v. Basham*, 471 F.3d 1199, 1205 (11th Cir. 2006). Nevertheless, they warrant separate analyses.

"Ripeness is peculiarly a question of timing. Its basic rationale is to prevent the courts, through premature adjudication, from entangling themselves in abstract disagreements." *Thomas v. Union Carbide Agr. Products Co.*, 473 U.S. 568, 580, 105 S. Ct. 3325, 87 L. Ed. 2d 409 (1985) (citations and alterations omitted). "A claim is not ripe for adjudication if it rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all." *Texas v. United States*, 523 U.S. 296, 300, 118 S. Ct. 1257, 140 L. Ed. 2d 406 (1998) (citation omitted). The ripeness inquiry turns on "'the fitness of the issues for judicial decision' and 'the hardship to the parties of withholding court consideration." *Pacific Gas and Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 201, 103 S. Ct. 1713, 75 L. Ed. 2d 752 (1983) (citation omitted). In the context of a facial challenge, as in this case, "a purely legal claim is presumptively ripe for judicial review because it does not require a developed factual record." *Harris v. Mexican Specialty Foods, Inc.*, 564 F.3d 1301, 1308 (11th Cir. 2009).

Because the individual mandate and employer mandate will not take effect until 2014, the defendants contend that those claims are unripe because no injury can occur before that time. However, "[w]here the inevitability of the operation of a statute against [plaintiffs] is patent, it is irrelevant to the existence of a justiciable controversy that there will be a time delay before the disputed provisions come into effect." *Blanchette v. Connecticut Gen. Ins. Corps.*, 419 U.S. 102, 143, 95 S. Ct. 335, 42 L. Ed. 2d 320 (1974). "The Supreme Court has long . . . held that where the enforcement of a statute is certain, a preenforcement challenge will not be rejected on ripeness grounds." *NAACP, supra*, 522 F.3d at 1164 (citing *Blanchette, supra*, 419 U.S. at 143).

The complained of injury in this case is "certainly impending" as there is no reason whatsoever to doubt that the federal government will enforce the individual mandate and employer mandate against the plaintiffs. Indeed, with respect to the individual mandate in particular, the defendants concede that it is absolutely necessary for the Act's insurance market reforms to work as intended. In fact, they refer to it as an "essential" part of the Act at least fourteen times in their motion to dismiss. It will clearly have to be enforced. *See Commonwealth of Pennsylvania v. State of West Virginia*, 262 U.S. 553, 592-93, 262 U.S. 553, 43 S. Ct. 658 (1923) (suit filed shortly after the challenged statute passed into law and before it was enforced was not premature where the statute "certainly would operate as the complainant states apprehended it would"). The individual mandate will have to be imposed and enforced against the plaintiffs and others because if it is not, and with proscriptions against insurance companies denying coverage for pre-existing medical conditions, there would the potential for an enormous moral hazard.

The fact that the individual mandate and employer mandate do not go into effect until 2014 does not mean that they will not be felt in the immediate or very near future. To be sure, responsible individuals, businesses, and states will have to start making plans now or very shortly to comply with the Act's various mandates. Individuals who are presently insured will have to confirm that their current plans comply with the Act's requirements and, if not, take appropriate steps to comply; the uninsured will need to research available insurance plans, find one that meets their needs, and begin budgeting accordingly; and employers and states will need to revamp their healthcare programs to ensure full compliance. I note that at least two courts considering challenges to the individual mandate have thus far denied motions to dismiss on standing and ripeness grounds. *See Virginia, supra*, 702 F. Supp. 2d at 607-08 (determining that because the individual mandate "radically changes the landscape of health insurance coverage in America," it will be felt by individuals, insurance carriers, employers, and states "in the near future"); *Thomas More Law Center v. Obama*, 2010 WL 3952805, at *4 (E.D. Mich. Oct. 7, 2010) ("[T]he government is requiring plaintiffs to undertake an expenditure, for which the government must anticipate that significant financial planning will be required. That financial planning must take place well in advance of the actual purchase of insurance in 2014 . . . There is nothing improbable about the contention that the Individual Mandate is causing plaintiffs to feel economic pressure today.")[11]

The Supreme Court and the Eleventh Circuit, as noted, have not hesitated to consider pre-enforcement challenges to the constitutionality of legislation when the complained of injury is certainly impending and more than a hypothetical possibility.

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[11] The defendants have recently filed a notice of supplemental authority in which they have attempted to distinguish *Thomas More Law Center* by claiming that the standing analysis in that case "hinge[d] on allegations not present here;" specifically, according to the defendants, the plaintiffs alleged in that case that "they were being compelled to 'reorganize their affairs,' and 'forego certain spending today, so they will have the funds to pay for health insurance when the Individual Mandate takes effect in 2014" (doc. 78 at 1-2). The defendants allege that "[t]he individual plaintiffs here make no comparable assertion." *See id.* That does not appear to be so. Ms. Brown has alleged that the individual mandate will force her to "divert resources from [her] business" and "reorder [her] economic circumstances" in order to obtain qualifying coverage. Am. Comp. ¶ 62.

Because the issues in this case are fully framed, and the relevant facts are settled, "[n]othing would be gained by postponing a decision, and the public interest would be well served by a prompt resolution of the constitutionality of [the statute]." *See Thomas, supra*, 473 U.S. at 582. Therefore, the case is ripe for review.[12]

Because the defendants' jurisdictional challenges fail, I will now turn to their arguments for failure to state a claim upon which relief can be granted under Rule 12(b)(6), Fed. R. Civ. P.

C. Rule 12(b)(6) Challenges for Failure to State a Claim Upon which Relief Can be Granted

A motion to dismiss for failure to state a claim under Rule 12(b)(6) will be granted if the complaint alleges no set of facts that, if proved, would entitle the plaintiff to relief. *Blackston v. Alabama*, 30 F.3d 117, 120 (11th Cir. 1994). On a motion to dismiss, the court must accept all the alleged facts as true and take all the inferences from those facts in the light most favorable to plaintiff. *See Cruz v. Beto*, 405 U.S. 319, 322, 92 S. Ct. 1079, 31 L. Ed. 2d 263

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[12] Further strengthening the conclusion that the public interest would be best served by a prompt resolution, I recognize that this court is but the first of probably several steps this case will take. Because that process will likely take another year or two, and because this court "will be in no better position later than we are now" to decide the case, *see Blanchette, supra*, 419 U.S. at 145, it would not serve the public interest to postpone the first step of this litigation until at least 2014.

(1972); *Hunnings v. Texaco, Inc.*, 29 F.3d 1480, 1484 (11th Cir. 1994). Although the Federal Rules do not require plaintiffs to set out in detail the facts on which they base their claim — Rule 8(a) only requires a "short and plain statement" showing that the plaintiff is entitled to relief — the complaint's "factual allegations must be enough to raise a right to relief above the speculative level." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007); *accord Ashcroft v. Iqbal*, — U.S. —, 129 S. Ct. 1937, 1949, 173 L. Ed. 2d 868 (2009) (explaining that "the pleading standard Rule 8 announces does not require 'detailed factual allegations,' but it demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation'"). Thus, "to survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Iqbal, supra*, 129 S. Ct. at 1949 (quoting *Twombly, supra*, 550 U.S. at 570). This does not "impose a probability requirement at the pleading stage." *See Twombly*, 550 U.S. at 556. Rather, the test is whether the complaint "succeeds in 'identifying facts that are suggestive enough to render [the claim] plausible.'" *See Watts v. Florida Int'l University*, 495 F.3d 1289, 1296 (11th Cir. 2007) (quoting *Twombly, supra*, 550 U.S. at 556).

The defendants claim that all counts in the amended complaint are deficient under Rule 12(b)(6); in other words, no cause of action is "plausible." Each claim must be both factually and legally plausible. This requires me to examine each of the claims factually and to "take a peek" at the status of the applicable existing Constitutional law.

Several of the plaintiffs' claims arise under Constitutional provisions for which the Supreme Court's interpretations have changed over the years. But, of course, the court is bound by the law as it exists now. Each count will be discussed below, in reverse order.

(1) Interference with state sovereignty as employers and performance of governmental functions (Count VI)

For this count, the plaintiffs object to the Act's employer mandate which requires the states, in their capacities as large employers, to offer and automatically enroll state employees in federally-approved insurance plans or else face substantial penalties and assessments. These "extensive new benefits," the plaintiffs contend, will "impose immediate and expensive requirements on the States that will continue to increase," *see* Pl. Mem. at 55-56, and "burden[ ] the States' ability to procure goods and services and to carry out governmental functions," *see* Am. Compl. ¶ 90. The employer mandate allegedly exceeds Article I of the Constitution and also runs afoul of state sovereignty in violation of the Ninth and Tenth Amendments.

Regardless of whether the employer mandate will be costly and burdensome to the states in their capacity as large employers (which at this stage of the case is assumed to be true), it is a "generally applicable" law that reaches both public and private employers alike. Although a law of general applicability, as opposed to one directed only at the states, is not per se Constitutional, it is a factor that the Supreme Court and the courts of appeal have consistently found to be significant. In the landmark case of *Garcia v. San Antonio Metro. Transit Auth.*, the Supreme Court held that a city's transit authority (SAMTA) was bound by the minimum wage and overtime pay provisions in the Fair Labor Standards Act ("FLSA"). During the course of its decision, the Court stated:

> [W]e need go no further than to state that we perceive nothing in the overtime and minimum-wage requirements of the FLSA, as applied to SAMTA, that is destructive of state sovereignty or violative of any constitutional provision. SAMTA faces nothing more than the same minimum-wage and overtime obligations that hundreds of thousands of other employers, public as well as private, have to meet.

469 U.S. 528, 554, 105 S. Ct. 1005, 83 L. Ed. 2d 1016 (1985*); see also Reno v. Condon*, 528 U.S. 141, 151, 120 S. Ct. 666, 145 L. Ed. 2d 587 (2000) (generally applicable law upheld that regulated the entire "universe of entities" in the market, both in the public and private realm, and applied "to individuals as well as States"); *see also Oklahoma Dep't of Public Safety v. United States*, 161 F.3d 1266, 1271 (10th Cir. 1998) (noting the "logical distinction" that the Supreme Court has drawn between generally applicable laws that "incidentally apply to states" and those that apply only to states; explaining that "because generally applicable laws are not aimed at uniquely governmental functions," and because such "laws affecting both private and public interests are subject to stricter political monitoring by the private sector," a law is less likely to be found oppressive

"where the law is aimed at both private and public entities"). The Seventh Circuit has thus stated:

> Neutrality between governmental and private spheres is a principal ground on which the Supreme Court has held that states may be subjected to regulation when they participate in the economic marketplace — for example, by hiring workers covered by the Fair Labor Standards Act. So long as public market participants are treated the same as private ones, they enjoy the protection the latter have been able to secure from the legislature; and as Congress is not about to destroy private industry (think what that would do to the tax base!) it can not hobble the states either.

Travis v. Reno, 163 F.3d 1000, 1002-03 (7th Cir. 1998) (citations omitted). I find these cases to be instructive. Although a law of general applicability may not be per se Constitutional, *see Condon, supra*, 528 U.S. at 151 (leaving the question open), the fact that the employer mandate is generally applicable goes a long way toward sustaining it.

Further, in this case, the mere fact that the states will be required to provide the same healthcare benefits to employees as private employers does not, by itself, implicate or interfere with state functions and sovereignty. In *Maryland v. Wirtz*, 392 U.S. 183, 88 S. Ct. 2017, 20 L. Ed. 2d 1020 (1968), the Supreme Court rejected the argument that extending FLSA wage and overtime pay provisions to the states would violate state sovereignty by telling public hospitals and schools how to carry out their sovereign functions:

> The Act establishes only a minimum wage and a maximum limit of hours unless overtime wages are paid, and does not otherwise affect the way in which school and hospital duties are performed. Thus appellants' characterization of the question in this case as whether Congress may, under the guise of the commerce power, tell the States how to perform medical and educational functions is not factually accurate. Congress has "interfered with" these state functions only to the extent of providing that when a State employs people in performing such functions it is subject to the same restrictions as a wide range of other employers whose activities affect commerce, including privately operated schools and hospitals.

Id. at 193-94. The state plaintiffs allege that the employer mandate will interfere with their sovereignty and impede state functions insofar as it will be financially burdensome and that, if it is allowed to stand, the state's authority "to define the conditions of its officeholders and employees and to control appropriations [will be] usurped." Pl. Mem. at 57; *see also id.* at 56 n.59 (contending that "Congress may [not] decree the basic terms of the employment relationship with State officers and employees and usurp the States' authority over their budgets and resources").

However, virtually any and all attempts to regulate the wages and conditions of employment in the national labor market (which Congress has long done) will result in similar restrictions and adversely impact the state fisc. The minimum wage and overtime pay provisions in the FLSA, which the

Supreme Court upheld against the states in *Wirtz* and *Garcia, supra*, certainly had much the same effect, as the dissenters in those cases made it a point to emphasize. *See Garcia, supra*, 469 U.S. at 528 ("The financial impact on States and localities of displacing their control over wages, hours, overtime regulations, pensions, and labor relations with their employees could have serious, as well as unanticipated, effects on state and local planning, budgeting, and the levying of taxes.") (Powell, J., dissenting); *Wirtz, supra*, 392 U.S. at 203 (stating that "[t]here can be no doubt" that if the FLSA is extended to the states it could "disrupt the fiscal policy of the States and threaten their autonomy in the regulation of health and education") (Douglas, J., dissenting). The majority opinions in those two cases control here, unless there is a discernable reason to treat healthcare benefits differently than compensation and conditions of employment.

I see no persuasive reason why healthcare benefits — which are generally viewed as a condition of employment and part of an employee's compensation package[13] — should be treated differently than other aspects of compensation and conditions of employment that the Supreme Court has already held Congress may regulate and mandate against the states (such as wages, hours, overtime pay, etc). This is particularly so in light of the fact that, as the defendants correctly point out, to some extent Congress already regulates health benefits for state employees, for example, with respect to COBRA's temporary continuation of coverage provisions and HIPAA's restrictions on the ability of group plans to deny coverage due to preexisting conditions. *See* Def. Mem. at 22. If the employer mandate in the Act is unconstitutional as applied to the states, for the reasons claimed by the plaintiffs, then the FLSA (and arguably COBRA and HIPAA) are likewise unconstitutional as applied to the states. The plaintiffs tried to distinguish *Garcia* during oral argument by contending that the case was justified because Congress there was trying to ensure that workers "were, in effect, not going to be abused with regard to hours or inadequate wages." Tr. at 79. Whether the plaintiffs feel that Congress had a more noble and well-meaning *purpose* in passing the FLSA is irrelevant. The *power* that Congress asserted (and the effect it would have on the state fisc) is essentially the same as here.

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[13] *Cf., e.g., Owen v. McKibben*, 78 Fed. Appx. 50, 51 n.3 (10th Cir. 2003) (compensation package at issue included healthcare insurance); *United States v. City of New York*, — F. Supp. 2d —, 2010 WL 1948562, at *1 (S.D.N.Y. May 13, 2010) (same); *Portugues-Santa v. B. Fernandez Hermanos, Inc.*, 614 F. Supp. 2d 221, 228 (D.P.R. 2009) (same); *Laselva v. Schmidt*, 2009 WL 1312559, *1 (N.D.N.Y. May 7, 2009) (same); *Plitt v. Ameristar Casino, Inc.*, 2009 WL 1297404, at *1 (E.D. Mo. May 6, 2009) (same); *Perrotti v. Wal-Mart Stores, Inc.*, 2006 WL 146232, *1 (D.N.H. Jan. 19, 2006) (same); *Hudson v.*

For the foregoing reasons, I believe *Wirtz* and *Garcia* control. I recognize that *Wirtz* (state employers subject to the FLSA) was overruled by *National League of Cities v. Usery*, 426 U.S. 833, 96

International Computer Negotiations, Inc., 2005 WL 3087865, at *1 (M.D. Fla. Nov. 16, 2005) (same).

S. Ct. 2465, 49 L. Ed. 2d 245 (1975) (state employers not subject to the FLSA), which was in turn overruled by *Garcia* (state employers once again subject to the FLSA). Accordingly, in light of this "unsteady path" of Supreme Court jurisprudence, *New York v. United States*, 505 U.S. 144, 160, 112 S. Ct. 2408, 120 L. Ed. 2d 120 (1992), the plaintiffs would most likely have stated a plausible claim if it had been brought between 1975 and 1985. But, of course, I am required to apply the law as it now exists.

Because the Act's employer mandate regulates the states as participants in the national labor market the same as it does private employers, and because the Supreme Court has held in this context that adversely impacting the state fisc (by requiring a minimum level of employment-based benefits) does not interfere with state sovereignty and impede state functions, the employer mandate does not violate the Constitution as a matter of law — under the current law. Therefore, Count Six does not state a plausible claim upon which relief can be granted and must be dismissed.[14]

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[14] The plaintiffs argue that the employer mandate runs afoul of the intergovernmental- tax-immunity doctrine, *see* Pl. Mem. at 58-60, but the defendants persuasively respond that the claim has not been pled in the amended complaint and that, in any event, it must fail as a matter of law, *see* Reply in Support of Defendants' Motion to Dismiss ("Reply Mem."), at 8-11 (doc. 74). Indeed, under the current state of the law, it is unclear if the inter-governmental-tax-immunity even retains any viability. *See South Carolina v. Baker*, 485 U.S. 505, 518 n.11, 108 S. Ct. 1355, 99 L. Ed. 2d 592 (1988) (noting the inter-

(2) Coercion and commandeering as to healthcare insurance (Count V)

The Act provides for the creation of health benefit exchanges to foster and provide "consumer choices and insurance competition." The Act gives the states the option to create and operate the exchanges themselves, or have the federal government do so. The plaintiffs acknowledge that they have a choice, but they claim it is tantamount to no choice because the Act forces them to operate the exchange "under threat of removing or significantly curtailing their long-held regulatory authority" (*see* Am. Compl. ¶ 88), which will "displace State authority over a substantial segment of intrastate insurance regulation . . . that the States have always possessed under the police powers provided in the Constitution." *See id.* ¶ 44. This is improper "coercion and commandeering" in violation of the Ninth and Tenth Amendments, according to the plaintiffs.

The plaintiffs' argument for this claim is directly foreclosed by *Hodel v. Virginia Surface Min. & Reclamation Association, Inc.*, 452 U.S. 264, 101 S. Ct. 2352, 69 L. Ed. 2d 1 (1981). That case involved a pre-enforcement challenge to the Surface Mining Control and Reclamation Act, which was a comprehensive statute designed to "'establish a nationwide program to protect society and the

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governmental-tax-immunity doctrine has "shifted into the modern era," and declining to decide "the extent, *if any*, to which States are currently immune from direct nondiscriminatory federal taxation") (emphasis added).

environment from the adverse effects of surface coal mining operations.'" *Id.* at 268. Pursuant to the statute, "any State wishing to assume permanent regulatory authority over the surface coal mining operations" was required to submit a "proposed permanent program" demonstrating compliance with federal regulations. *Id.* at 271. If any state chose not to do so, the statute provided that the Secretary of the Interior would "develop and implement" the program for that particular state. Virginia filed suit and alleged that the statute violated the Constitution in that "the threat of federal usurpation of their regulatory roles coerces the States into enforcing the Surface Mining Act." *Id.* at 289. The district court agreed, reasoning that while the statute "allows a State to elect to have its own regulatory program, the 'choice that is purportedly given is no choice at all' because the state program must comply with federally prescribed standards." *Id.* at 285 n.25. However, the Supreme Court flatly rejected the argument and reversed. In doing so, the Court explained that the statute merely established "a program of cooperative federalism that allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory programs, structured to meet their own particular needs." *Id.* at 289. It "prescribes federal minimum standards governing surface coal mining, which a State may either implement itself or else yield to a federally administered regulatory program." *Id.* The Supreme Court further stated that:

> A wealth of precedent attests to congressional authority to displace or pre-empt state laws

> regulating private activity affecting interstate commerce when these laws conflict with federal law. Although such congressional enactments obviously curtail or prohibit the States' prerogatives to make legislative choices respecting subjects the States may consider important, the Supremacy Clause permits no other result.
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> * * *
>
> Thus, Congress could constitutionally have enacted a statute prohibiting any state regulation of surface coal mining. We fail to see why the Surface Mining Act should become constitutionally suspect simply because Congress chose to allow the States a regulatory role.

Id. at 290 (citations omitted). Notably, the Court made it a point to emphasize that its conclusion applied even though — as the plaintiffs maintain in this case — "the federal legislation displaces laws enacted under the States' 'police powers.'" *Id.* at 291.

Commandeering was found in *New York, supra,* 505 U.S. at 144, where Congress passed a statute requiring state legislatures to enact a particular kind of law, and that holding was later extended in *Printz v. United States,* 521 U.S. 898, 117 S. Ct. 2365, 138 L. Ed. 2d 914 (1997), to apply to individual state officials. *Id.* at 935 (holding that "Congress cannot circumvent [the prohibition in *New York*] by conscripting the State's officers directly"). The plaintiffs rely heavily on these two decisions for their argument, but both cases are factually and substantively different from the one here. The plaintiffs have not identified any provision in the Act that requires the states to enact a particular law or regulation, as in *New York*, nor have they identified any provision that requires state officials to enforce federal laws that regulate private individuals, as in *Printz*. "[T]he anti-commandeering rule comes into play only when the federal government calls on the states to use their sovereign powers as regulators of their citizens." *Travis, supra*, 163 F.3d at 1004- 05 (emphasis added); see also id. at 1004 (noting that states may be objects of regulation but "cannot be compelled to become regulators of private conduct"). Indeed, both *New York* and *Printz* cited *Hodel* with approval and distinguished it from the facts presented in those two cases. *See Printz, supra*, 521 U.S. at 925-26 (explaining "the Federal Government may not compel the States to implement, by legislation or executive action, federal regulatory programs," which the legislation at issue in *Hodel* did not do "because it merely made compliance with federal standards a precondition to continued state regulation in an otherwise pre-empted field"); *New York, supra*, 505 U.S. at 161, 167 (the statute at issue in *Hodel* was an example of "cooperative federalism" that did not commandeer the legislative process because the states were not compelled to enforce the statute, expend any state funds, or participate in the program "in any manner whatsoever"; they could have elected not to participate and "the full regulatory burden will be borne by the Federal Government"). Because the health benefit exchanges are voluntary and do not compel states to regulate private conduct of their citizens, Count Five does not state a claim upon which relief can be granted. The Act gives the states the choice to establish the exchanges, and is therefore the type of cooperative federalism that was authorized in *Hodel, supra.*[15]

(3) Coercion and commandeering as to Medicaid (Count IV)

For this claim, the state plaintiffs object to the "fundamental changes in the nature and scope of the Medicaid program" that the Act will bring about. *See* Am. Comp. ¶ 86. They have described these changes at length in their complaint, *see* Am. Comp. ¶¶ 39-60, and they need not be repeated here in any great detail. It is sufficient to say that the state plaintiffs maintain that the Act drastically expands and alters the Medicaid program to such an extent they cannot afford the newly-imposed costs as it will force them to "run [their] budgets off a cliff." Tr. 72. The Medicaid provisions in the Act allegedly run afoul of Congress's Article I powers; exceed the Commerce Clause; and violate the Ninth and Tenth Amendments.

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[15] The plaintiffs appear to suggest that our case is distinguishable from *Hodel* because, unlike the statute under review in that case, the federal government here has not accepted the "full regulatory burden" of the health benefit exchanges. For this, the plaintiffs rely on six statutory provisions that they maintain "conscript and coerce States into carrying out critical elements of the insurance exchange program." *See* Pl. Mem. at 51-54. As the defendants correctly point out, however, *see* Reply Mem. at 6-7, upon close and careful review, each challenged provision is voluntary and generally applicable only if the state elects to establish the exchange.

The defendants do not appear to deny that the Act will significantly alter and expand the Medicaid program as it currently exists (although they do point out that the federal government will be absorbing 100% of the new costs for the first three years[16]). Rather, the defendants rest their argument on this simple and unassailable fact: state participation in Medicaid under the Act is, as it always has been, entirely voluntary. When the freedom to opt out of the program is considered in conjunction with the fact that Congress has expressly reserved the right to alter and amend the program, *see* 42 U.S.C. § 1304 ("The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress."), and, in fact, it has done so numerous times over the years, *see* Def. Mem. at 10, the defendants contend that the state plaintiffs have failed to state a claim. *See Harris v. McRae*, 448 U.S. 297, 301, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980) (noting "[a]lthough participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements" that Congress sees fit to impose).

The state plaintiffs assert that they do not actually have the freedom to opt out. They note that "'Medicaid is the single largest Federal grant-in-aid program to the States, accounting for over 40 percent of all Federal grants to states.'" *See* Pl. Mem.

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[16] One could argue, however, that the "federal government" will not really be absorbing the costs as the government has little money except through taxpayers, who almost exclusively reside within the states.

at 50 (quoting Bipartisan Comm'n on the Medicaid Act of 2005, H.R. 985, 109th Cong. § 2(13) (2005)). They further note that in Florida, for example, 26% of its budget is presently devoted to Medicaid outlays, and because the federal government contributes an average of 55.45% of Medicaid costs, Florida's outlays would have to be more than doubled (to the point of consuming more than 58% of its state budget) to offer the same level of benefits that its Medicaid enrollees now receive. In short, the plaintiffs contend that the Act imposes a Hobson's Choice. They must either: (1) accept the Act's transformed Medicaid program with all its new obligations and costs that the states cannot afford; or (2) exit the program altogether and lose federal matching funds that are necessary and essential for them to provide healthcare to their neediest citizens (along with other Medicaid-linked federal funds). Either way, they contend that their Medicaid systems will eventually collapse, leaving millions of their neediest residents without any health insurance. Consequently, they claim that they are being forced into accepting the changes to the Medicaid program — even though they cannot afford it and doing so will work an enormous financial hardship — because they "effectively have no choice other than to participate." *See* Am. Comp. ¶ 84. Although this claim has intuitive appeal, the status of existing law makes it a close call as to whether it states a "plausible" claim upon which relief can be granted.

The underlying question presented is whether the Medicaid provisions satisfy the Spending Clause. There are four "general restrictions" on Congress's spending power: (1) the exercise of spending power must be for the general welfare; (2) the conditions must be stated clearly and unambiguously; (3) the conditions must bear a relationship to the purpose of the program; and (4) the conditions imposed may, of course, not require states "to engage in activities that would themselves be unconstitutional." *See generally South Dakota v. Dole*, 483 U.S. 203, 207-10, 107 S. Ct. 2793, 97 L. Ed. 2d 171 (1987). The plaintiffs do not appear to dispute that the Act meets these restrictions. Rather, their claim is based principally on a single sentence near the end of *Dole*, where the Supreme Court speculated that "in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* at 211. For that statement, the Court relied upon an earlier decision, *Steward Machine Co. v. Davis*, 301 U.S. 548, 57 S. Ct. 883, 81 L. Ed. 1279 (1937), which likewise speculated that there may be a point at which Congressional pressure turns into impermissible coercion. However, the *Steward Machine* Court made no attempt to define exactly where that line might be drawn and, in fact, suggested that no such line could be drawn. Justice Cardozo cautioned that any spending measure (in that case, in the form of a tax rebate) "conditioned upon conduct is in some measure a temptation. But to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." *Id.* at 589-90.

Accordingly, the coercion theory has been often discussed in case law and scholarship, but never actually applied. While it appears that the Eleventh

Circuit has not yet been called upon to consider the issue, the courts of appeal that have considered the theory have been almost uniformly hostile to it. *See, e.g., Doe v. Nebraska*, 345 F.3d 593, 599 (8th Cir. 2003) (acknowledging what the Supreme Court said in *Dole*, but going on to note that the "circuits are in accord" with the view that no coercion is present if a state — even when faced with the possible "sacrifice" of a large amount of federal funding — voluntarily exercises its own choice in accepting the conditions attached to receipt of federal funds; noting that a "politically painful" choice does not compulsion make); *Kansas v. United States*, 214 F.3d 1196, 1201-02 (10th Cir. 2000) ("The cursory statements in *Steward Machine* and *Dole* mark the extent of the Supreme Court's discussion of the coercion theory. The Court has never employed the theory to invalidate a funding condition, and federal courts have been similarly reluctant to use it"; the theory is "unclear, suspect, and has little precedent to support its application."); *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989) ("The coercion theory has been much discussed but infrequently applied in federal case law, and never in favor of the challenging party. . . . The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments."); *Oklahoma v. Schweiker*, 655 F.2d 401, 413-14 (D.C. Cir. 1981) (pre-*Dole*) (coercion argument rejected because courts "are not suited to evaluating whether states are faced here with an offer they cannot refuse or merely a hard choice. Even a rough assessment of the degree of temptation would require extensive and complex factual inquiries on a state-by-state basis. We therefore follow the lead of other courts that have explicitly declined to enter this thicket when similar funding conditions have been at issue."); *State of New Hampshire Dep't of Employment Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980) (pre- *Dole*) ("Petitioners argue, however, that this option of the state to refuse to participate in the program is illusory, since the severe financial consequences that would follow such refusal negate any real choice . . . . We do not agree that the carrot has become a club because rewards for conforming have increased. It is not the size of the stakes that controls, but the rules of the game.").

Perhaps the case most analogous to this one is *California v. United States*, 104 F.3d 1086 (9th Cir. 1997), where California challenged the Medicaid program, in pertinent part, because it conditioned the receipt of federal matching funds on the provision of emergency medical services to illegal aliens. Because illegal aliens comprised 5% of its population, the state was having to spend $400 million each year on providing health care to the aliens. California objected to having to spend that money and argued, like plaintiffs here, that it was being coerced into doing so because, while its initial decision to participate in Medicaid was voluntary, "it now has no choice but to remain in the program in order to prevent a collapse of its medical system." In rejecting this argument, the Ninth Circuit questioned the "viability" of the coercion theory, as well as the possibility that any "sovereign state which is always free to increase its tax revenues [could] ever be coerced by the withholding of federal funds." The Court of Appeals concluded — as have all courts to have considered the issue — that the state was merely presented with a "hard political choice." *See generally id.* at 1089-92; *accord Padavan v. United States*, 82 F.3d 23, 28-29 (2d Cir. 1996) (holding same and noting that "Medicaid is a voluntary program in which states are free to choose whether to particulate. If New York chose not to participate, there would be no federal regulation requiring the state to provide medical services to illegal aliens").

The Fourth Circuit appears to be the one circuit where the coercion theory has been considered and "is not viewed with such suspicion." *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 290 (4th Cir. 2002) (referencing a prior decision of that court, *Commonwealth of Virginia Dep't of Education v. Riley*, 106 F.3d 559 (4th Cir. 1997), where six of the thirteen judges on the *en banc* panel stated in dicta that coercion theory may be viable). Notwithstanding that the theory may be available in the Fourth Circuit, *West Virginia* acknowledged that because of "strong doubts about the viability of the coercion theory"; in light of the fact that it is "somewhat amorphous and cannot easily be reduced to a neat set of black-letter rules of application"; and given the "difficulties associated with [its] application," there is "no decision from any court finding a conditional grant to be impermissibly coercive." Therefore, "most courts faced with the question have effectively abandoned any real effort to apply the coercion theory" after finding, in essence, that it "raises political questions that cannot be resolved by the courts." *See id.* at 288-90. All this to say, if the coercion theory stands at all, it stands on extremely "wobbly legs." *See Skinner, supra*, 884 F.2d at 454.

In light of the foregoing, the current status of the law provides very little support for the plaintiffs' coercion theory argument. Indeed, when the "pressure turns into compulsion" theory is traced back, its entire underpinning is shaky. In *Steward Machine Co., supra*, the Supreme Court held that there was no coercion because "[n]othing in the case suggests the exertion of a power akin to undue influence, *if we assume that such a concept can ever be applied with the fitness to the relations between state and nation.*" 301 U.S. at 590 (emphasis added). Thus, in addition to being left undefined, the theory appears to stem from a "what if" assumption. Nevertheless, while the law does not provide much support for the plaintiffs' argument, it does not preclude it either (at least not in this circuit).

Further, I cannot ignore that, based on the allegations in the complaint, the plaintiffs are in an extremely difficult situation. They either accept the sweeping changes to Medicaid (which they contend will explode their state budgets), or they withdraw from the system entirely (which they allege could leave millions of their poorest and neediest citizens without any medical coverage). The plaintiffs have argued that this is tantamount to no choice at all, which can perhaps be inferred from the fact that Congress does not really anticipate that the states will (or could) drop out of the Medicaid program. To be sure, since the Act seeks to reduce costs, reduce uncompensated care, and reduce the number of uninsured, it would make little sense for Congress to expect that objecting states would opt out of Medicaid and leave millions of the country's poorest citizens without medical coverage, and thus make each of those stated problems significantly worse.

In addition, if the state plaintiffs make the decision to opt out of Medicaid, federal funds taken from their citizens via taxation that used to flow back into the states from Washington, D.C., would instead be diverted to the states that have agreed to continue participating in the program.[17]

If the Supreme Court meant what it said in *Dole* and *Steward Machine Co.* (and I must presume that it did), there is a line somewhere between mere pressure and impermissible coercion. The reluctance of some circuits to deal with this issue because of the potential legal and factual complexities is not entitled to a great deal of weight, because courts deal every day with the difficult complexities of applying Constitutional principles set forth and defined by the Supreme Court. Because the Eleventh Circuit (unlike the other circuits) has apparently not directly addressed and foreclosed this argument, and because, in any event, "the location of the point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, *of fact*," *Steward Machine Co., supra*, 301 U.S. at 590 (emphasis added), the plaintiffs have stated a "plausible" claim in this circuit.

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[17] *See, e.g.*, Lynn A. Baker, *The Spending Power and the Federalist Revival*, 4 Chap. L. Rev. 195, 213-14 (2001) ("[S]hould a state decline proffered federal funds because it finds a condition intolerable, it receives no rebate of any tax dollars that its residents have paid into the federal fisc. In these cases, the state (through its residents) contributes a proportional share of federal revenue only to receive less than a proportional share of federal spending. Thus, when the federal government offers the states money, it can be understood as simply offering to return the states' money to them, often with unattractive conditions attached.").

(4) Violation of constitutional prohibition of unapportioned capitation or direct tax (Count III)

For this count, the plaintiffs object to the individual mandate penalty. They make an "alternative" claim that, *if* the penalty is a tax (which they do not believe it is, and some Constitutional authorities have concluded it could not be[18]), it is an unconstitutional capitation or direct tax, prohibited by Article I, Section 9, Clause 4 of the Constitution.[19] Although the argument is not only plausible, but appears to have actual merit, as some commentators have noted, *see, e.g.*, Steven J. Willis and Nakku Chung, *Constitutional Decapitation and Healthcare*, Tax Notes (2010), I need not be concerned with the issue. As previously explained, it is quite clear that Congress did not intend the individual mandate penalty to be a tax; it is a penalty. It must be analyzed on the basis of whether it is authorized under Congress's Commerce Clause power, not its taxing power. Therefore, Count Three will be dismissed as moot.

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[18] *See, e.g.*, Randy Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional*, N.Y.U. J.L. & Liberty (forthcoming), at 27 (stating that the argument for the penalty being justified under Congress's broad taxing authority is based on a "radical" theory that, if accepted, would authorize Congress "to penalize or mandate any activity by anyone in the country, provided it limited the sanction to a fine enforced by the Internal Revenue Service," which would "effectively grant Congress a general police power").

[19] This is the same Constitutional provision under which the Supreme Court held that the first attempt to impose a federal income tax was unconstitutional to the extent it was not apportioned. *See generally Pollock v. Farmers' Loan & Trust Co.*, 157 U.S. 429, 15 S. Ct. 673, 39 L. Ed. 759 (1895). Subsequently, passage of the Sixteenth Amendment in 1913

(5) Challenge to individual mandate on due process grounds (Count II)

The plaintiffs next allege that the individual mandate violates their rights to substantive due process under the Fifth Amendment. Again, this claim would have found Constitutional support in the Supreme Court's decisions in the years prior to the New Deal legislation of the mid-1930's, when the Due Process Clause was interpreted to reach economic rights and liberties. *See Lochner v. New York*, 198 U.S. 45, 25 S. Ct. 539, 49 L. Ed. 937 (1905); see also *Coppage v. Kansas*, 236 U.S. 1, 35 S. Ct. 240, 59 L. Ed. 441 (1915), *Adkins v. Children's Hospital*, 261 U.S. 525, 43 S. Ct. 394, 67 L. Ed. 785 (1923); *Jay Burns Baking Co. v. Bryan*, 264 U.S. 504, 44 S. Ct. 412, 68 L. Ed. 813 (1924). However, "[t]he doctrine that prevailed in *Lochner*, *Coppage*, *Adkins*, *Burns*, and like cases — that due process authorizes

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authorized the imposition of an income tax without the need for apportionment among the states.

courts to hold laws unconstitutional when they believe the legislature has acted unwisely — has long since been discarded." *Ferguson v. Skrupa*, 372 U.S. 726, 730, 83 S. Ct. 1028, 10 L. Ed. 2d 93 (1963); *see also New Motor Vehicle Bd. v. Orrin W. Fox Co.*, 439 U.S. 96, 106-07, 99 S. Ct. 403, 58 L. Ed. 2d 361 (1978) (since the demise of substantive due process in the arena of economic regulation, legislatures have "broad scope to experiment with economic problems").

Therefore, as the law now exists, if a challenged statute does not implicate the very limited and narrow class of rights that have been labeled "fundamental," courts reviewing legislative action on substantive due process grounds will accord substantial deference to the legislative judgments. In the absence of a fundamental right, the question is not whether the court thinks the legislative action is wise, but whether the legislature could reasonably conclude that the measure at issue is "rationally related" to a legitimate end. As the Eleventh Circuit has explained:

> Substantive due process claims not involving a fundamental right are reviewed under the rational basis test. The rational basis test is not a rigorous standard [and] is generally easily met. A searching inquiry into the validity of legislative judgments concerning economic regulation is not required. . . . The task is to determine if "any set of facts may be reasonably conceived to justify" the legislation. . . . To put it another way, the legislation must be sustained if there is any conceivable basis for the legislature to believe that the means they have selected will tend to

> accomplish the desired end. Even if the court is convinced that the political branch has made an improvident, ill-advised or unnecessary decision, it must uphold the act if it bears a rational relation to a legitimate governmental purpose.

TRM, Inc. v. United States, 52 F.3d 941, 945-46 (11th Cir. 1995) (citations omitted).

The plaintiffs contend that the individual mandate does, in fact, implicate fundamental rights to the extent that people have "recognized liberty interests in the freedom to eschew entering into a contract, to direct matters concerning dependent children, and to make decisions regarding the acquisition and use of medical services." *See* Pl. Mem. at 43-44; *accord* Tr. at 82 ("The fundamental interest involved here, aside from the liberty of contract, is the right to . . . bodily autonomy and use of medical care . . . the right to run your family life as you see fit with some limited intrusions available"). Fundamental rights are a narrow class of rights involving the rights to marry, have children, direct the education of those children, marital privacy, contraception, bodily integrity, and abortion; and the Supreme Court is "very reluctant to expand" that list. *See Doe v. Moore*, 410 F.3d 1337, 1343 (11th Cir. 2005). There is, to be sure, a liberty interest in the freedom to be left alone by the government. We all treasure the freedom to make our own life decisions, including what to buy with respect to medical services. Is that a "fundamental right"? The Supreme Court has not indicated that it is — at least not yet. That is the current state of the law, and it is not a district court's place to expand upon that law.

Congress made factual findings in the Act and concluded that the individual mandate was "essential" to the insurance market reforms contained in the statute. This is a "rational basis" justifying the individual mandate — if it does not relate to a fundamental right, which only the Supreme Court can recognize. In the absence of such a recognized fundamental right, that stated "rational basis" is sufficient to withstand a substantive due process challenge. This count must be dismissed.

(6) Challenge to individual mandate as exceeding Commerce Clause (Count I)

Under the Commerce Clause, Congress may regulate: (1) the channels of interstate commerce; (2) the instrumentalities of interstate commerce; and (3) activities "affecting" interstate commerce. *Perez v. United States*, 402 U.S. 146, 150, 91 S. Ct. 1357, 28 L. Ed. 2d 686 (1971). Only (3) is at issue here.

For this count, the plaintiffs maintain that the individual mandate does not regulate activity affecting interstate commerce; instead, it seeks to impermissibly regulate economic *inactivity*. The decision not to buy insurance, according to the plaintiffs, is the exact opposite of economic activity. Because the individual mandate "compels all Americans to perform an affirmative act or incur a penalty, simply on the basis that they exist and reside within any of the United States," the plaintiffs contend that it will deprive them of "their rights under State law to make personal healthcare decisions without governmental interference." Am. Comp. ¶¶ 70, 75. Thus alleged, the individual mandate exceeds the Commerce Clause, and violates the Ninth and Tenth Amendments.

The defendants, of course, have a different take. They contend that "[t]he appearance of inactivity here is just an illusion" because the people who decide to not buy insurance are participating in the relevant economic market. *See* Tr. at 30. Their argument on this point can be broken down to the following syllogism: (1) because the majority of people will at some point in their lives need and consume healthcare services, and (2) because some of the people are unwilling or unable to pay for those services, (3) Congress may regulate everyone and require that everyone have specific, federally-approved insurance. Framed this way, the defendants insist that the individual mandate does not require people to pay for a service they do not want; rather, it merely tells them how they must pay for a service they will almost certainly consume in the future.

It is, according to the defendants, no different than Congress telling people "you need to pay by cash instead of check or credit card." Tr. at 88; *accord* Def. Mem. at 43 ("[Individuals who choose not to buy insurance] have not opted out of health care; they are not passive bystanders divorced from the health care market. Instead, they have chosen a method of payment for services they will receive, no more 'inactive' than a decision to pay by credit card rather than by check."). Also, because the individual mandate is essential to the insurance market reforms in the Act, the defendants argue that it is sustainable for the "second reason" that it falls within the Necessary and Proper Clause. *See* Def. Mem. at 44-48.

At this stage in the litigation, this is not even a close call. I have read and am familiar with all the pertinent Commerce Clause cases, from *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 6 L. Ed. 23 (1824), to *Gonzales v. Raich*, 545 U.S. 1, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005). I am also familiar with the relevant Necessary and Proper Clause cases, from *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 4 L. Ed. 579 (1819), to *United States v. Comstock*, — U.S. —, 130 S. Ct. 1949, 176 L. Ed. 2d 878 (2010). This case law is instructive, but ultimately inconclusive because the Commerce Clause and Necessary and Proper Clause have never been applied in such a manner before. The power that the individual mandate seeks to harness is simply without prior precedent. The Congressional Research Service (a nonpartisan legal "think tank" that works exclusively for Congress and provides analysis on the constitutionality of pending legislation) advised Congress on July 24, 2009, long before the Act was passed into law, that "it is unclear whether the [Commerce Clause] would provide a solid constitutional foundation for legislation containing a requirement to have health insurance." The analysis goes on to state that the individual mandate presents "the most challenging question . . . as it is a novel issue whether Congress may use this clause to require an individual to purchase a good or service." Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, July 24, 2009, at 3. Even *Thomas More Law Center, supra*, 2010 WL 3952805, which recently upheld the individual mandate, seems to recognize that the individual mandate is without any precedent. *See id.* at *8 ("The Supreme Court has always required an economic or commercial component in order to uphold an act under the Commerce Clause. The Court has never needed to address the activity/inactivity distinction advanced by plaintiffs because in every Commerce Clause case presented thus far, there has been some sort of activity").[20]

The defendants "firmly disagree" with the characterization of the individual mandate as "unprecedented" and maintain that it is "just false" to suggest that it breaks any new ground. *See* Tr. 31, 33. During oral argument, as they did in their memorandum, *see* Def. Mem. at 44, they attempted to analogize this case to ***Heart of Atlanta Motel, Inc. v. United States***, 379 U.S. 241, 85 S. Ct. 348, 13 L. Ed. 2d 258 (1964), which held that Congress had the power under the Commerce Clause and the Civil Rights Act to require a local motel to rent rooms to black guests; and ***Wickard v. Filburn***, 317 U.S. 111, 63 S. Ct. 82, 87 L. Ed. 122 (1942), which held that Congress could limit the amount of wheat grown for personal consumption on a private farm in an effort to control supply and avoid surpluses or shortages that could result in abnormally low or high wheat prices. The defendants have therefore suggested that because the motel owner in *Heart of Atlanta* was required to rent rooms to a class of people he did not want to serve, Congress was regulating inactivity. And, because the farmer in *Wickard* was limited in the amount of wheat he could grow for his own personal consumption, Congress was forcing him t buy a product (at least to the extent that he wanted or needed more wheat than he was allowed). There are several obvious ways in which *Heart of Atlanta* and *Wickard* differ markedly from this case, but I will only focus on perhaps the most significant one: the motel owner and the farmer were each involved in an *activity* (regardless of whether it could readily be deemed interstate commerce) and each had a choice to discontinue that activity. The plaintiff in the former was not required to be in the motel business, and the plaintiff in the latter did not have to grow wheat (and if he did decide to grow the wheat, he could have opted to stay within his allotment and use other grains to feed his livestock — which would have been most logical, since wheat is usually more expensive and not an economical animal feed — and perhaps buy flour for him and his family). Their respective obligations under the laws being challenged were tethered to a voluntary undertaking. Those cases, in other words, involved activities in which the plaintiffs had chosen to engage. All Congress was doing was saying that if you *choose* to engage in the activity of operating a motel or growing wheat, you are engaging in interstate commerce and subject to federal authority.

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[20] The district court, however, went on to adopt the government's argument that the Commerce Clause should not only reach economic activity — which had "always" been present in "every Commerce Clause case" decided to date — but it should be applied to "economic decisions" as well, such as the decision not to buy health insurance.

But, in this case we are dealing with something very different. The individual mandate applies across the board. People have no choice and there is no way to avoid it. Those who fall under the individual mandate either comply with it, or they are penalized. It is not based on an activity that they make the choice to undertake. Rather, it is based solely on citizenship and on being alive. As the nonpartisan CBO concluded sixteen years ago (when the individual mandate was considered, but not pursued during the 1994 national healthcare reform efforts): "A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action. The government has never required people to buy any good or service *as a condition of lawful residence in the United States.*" *See* Congressional Budget Office Memorandum, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance*, August 1994 (emphasis added).

Of course, to say that something is "novel" and "unprecedented" does not necessarily mean that it is "unconstitutional" and "improper." There may be a first time for anything. But, at this stage of the case, the plaintiffs have most definitely stated a plausible claim with respect to this cause of action.[21]

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[21] Starting in the First World War, there have been at least six attempts by the federal government to introduce some kind of universal healthcare insurance coverage. At no point — until now — did it mandate that everyone buy insurance (although it was considered during the healthcare reform efforts in 1994, as noted above). While the novel and unprecedented nature of the individual mandate does not automatically render it unconstitutional, there is perhaps a *presumption* that it is. In *Printz, supra*, 521 U.S. at 898, the Supreme Court stated

IV. CONCLUSION

The Supreme Court has said:

> Some truths are so basic that, like the air around us, they are easily overlooked. Much of the Constitution is concerned with setting forth the form of our government, and the courts have traditionally invalidated measure deviating from that form. The result may appear "formalistic" in a given case to partisans of the measure at issue, because such measures are typically the product of the era's perceived necessity. But the Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day.

New York, supra, 505 U.S. at 187. As noted at the outset of this order, there is a widely recognized need to improve our healthcare system. How to

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several times that an "absence of power" to do something could be inferred because Congress had never made an attempt to exercise that power before. *See id.* at 905 (stating that if "earlier Congresses avoided use of this highly attractive power, we would have reason to believe that the power was thought not to exist"); *see id.* at 907-08 ("the utter lack of statutes imposing obligations [like the one at issue there] (notwithstanding the attractiveness of that course to Congress), suggests an assumed *absence* of such power") (emphasis in original); *see id.* at 918 (stating "almost two centuries of apparent congressional avoidance of the practice [at issue] tends to negate the existence of the congressional power asserted here").

accomplish that is quite controversial. For many people, including many members of Congress, it is one of the most pressing national problems of the day and justifies extraordinary measures to deal with it. However, "a judiciary that licensed extraconstitutional government with each issue of comparable gravity would, in the long run, be far worse." *See id.* at 187-88. In this order, I have not attempted to determine whether the line between Constitutional and extraconstitutional government *has* been crossed. That will be decided on the basis of the parties' expected motions for summary judgment, when I will have the benefit of additional argument and all evidence in the record that may bear on the outstanding issues. I am only saying that (with respect to two of the particular causes of action discussed above) the plaintiffs have at least stated a plausible claim that the line has been crossed.

Accordingly, the defendants' motion to dismiss (doc. 55) is GRANTED with respect to Counts Two, Five, and Six, and those counts are hereby DISMISSED. The motion is DENIED with respect to Counts One and Four. Count Three is also DISMISSED, as moot. The case will continue as to Counts One and Four pursuant to the scheduling order previously entered.

DONE and ORDERED this 14th day of October, 2010.

/s/ Roger Vinson

ROGER VINSON

Senior United States District Judge

Appendix C

U.S. Const., art. I § 8, cl. 1, The General Welfare Clause of the United States Constitution

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States[.]

U.S. Const. art. I § 8, cl. 3, The Commerce Clause of the United States Constitution

The Congress shall have Power to regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes[.]

U.S. Const. art. I § 8, cl. 18, The Necessary and Proper Clause of the United States Constitution

The Congress shall have Power to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.

U.S. Const., amend. X
Reserved Powers to States

The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

RELEVANT PROVISIONS OF THE PATIENT PROTECTION & AFFORDABLE CARE ACT, PUB. L. NO. 111-148, AS AMENDED BY THE HEALTH CARE & EDUCATION RECONCILIATION ACT OF 2010, PUB. L. NO. 111-152

SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

"Subpart I—General Reform";

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

"SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage."; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg–1)—

(i) by striking the section heading and all that follow through subsection (a);

(ii) in subsection (b)—

(I) by striking "health insurance issuer offering health insurance coverage in connection with a group health plan" each place that such appears and inserting "health insurance issuer offering group or individual health insurance coverage"; and

(II) in paragraph (2)(A)—

(aa) by inserting "or individual" after "employer"; and

(bb) by inserting "or individual health coverage, as the case may be" before the semicolon; and

(iii) in subsection (e)—

(I) by striking "(a)(1)(F)" and inserting "(a)(6)";

(II) by striking "2701" and inserting "2704"; and

(III) by striking "2721(a)" and inserting "2735(a)"; and

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

“SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

“(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

“(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

“(A) such rate shall vary with respect to the particular plan or coverage involved only by—

“(i) whether such plan or coverage covers an individual or family;

“(ii) rating area, as established in accordance with paragraph (2);

“(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

“(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

“(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

“(2) RATING AREA.—

“(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

"(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

"(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

"(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

"(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market in the State.

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.

(G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold.

(H) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South- Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme

Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

"Sec. 5000A. Requirement to maintain minimum essential coverage.

"SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

"(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.— An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

"(b) SHARED RESPONSIBILITY PAYMENT.—

"(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

"(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

"(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

"(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

"(c) AMOUNT OF PENALTY.—

"(1) IN GENERAL.—The penalty determined under this subsection for any month with respect to any individual is an amount equal to 1/12 of the applicable dollar amount for the calendar year.

"(2) DOLLAR LIMITATION.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to 300 percent the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

"(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $750.

"(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.

"(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.— If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

"(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

"(i) $750, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

"(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

"(i) the modified gross income of the taxpayer, plus

"(ii) the aggregate modified gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(C) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

"(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (10) of section 62(a),

"(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

"(iii) determined without regard to sections 911, 931, and 933.

"(D) POVERTY LINE.—

"(i) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

"(ii) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.

"(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

"(2) RELIGIOUS EXEMPTIONS.—

"(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

"(B) HEALTH CARE SHARING MINISTRY.—

"(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

"(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

"(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

"(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

"(III) members of which retain membership even after they develop a medical condition,

"(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the

United States or an alien lawfully present in the United States.

"(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

"(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

"(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

"(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

"(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

"(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

"(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

"(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall be made by reference to the affordability of the coverage to the employee.

"(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the

Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

"(2) TAXPAYERS WITH INCOME UNDER 100 PERCENT OF POVERTY LINE.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).

"(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

"(4) MONTHS DURING SHORT COVERAGE GAPS.—

"(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

"(B) SPECIAL RULES.—For purposes of applying this paragraph—

"(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur, "(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

"(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

"(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

"(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

"(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:

"(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

"(i) the Medicare program under part A of title XVIII of the Social Security Act,

"(ii) the Medicaid program under title XIX of the Social Security Act, "(iii) the CHIP program under title XXI of the Social Security Act,

"(iv) the TRICARE for Life program,

"(v) the veteran's health care program under chapter 17 of title 38, United States Code, or

"(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

"(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

"(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

"(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

"(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

"(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

"(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

"(B) any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

"(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—

"(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

"(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

"(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

"(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

"(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

"(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

"(g) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) SPECIAL RULES.—Notwithstanding any other provision of law—

"(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

"(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

"(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

"(ii) levy on any such property with respect to such failure.".

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGEEMPLOYERS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18 (29 U.S.C. 218) the following:

"SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

"In accordance with regulations promulgated by the Secretary, an employer to which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans shall automatically enroll new fulltime employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Any automatic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee were automatically enrolled in. Nothing in this section shall be construed to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section.".

SEC. 1512. EMPLOYER REQUIREMENT TO INFORM EMPLOYEES OF COVERAGE OPTIONS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 18A (as added by section 1513) the following:

"SEC. 18B. NOTICE TO EMPLOYEES.

"(a) IN GENERAL.—In accordance with regulations promulgated by the Secretary, an employer to which this Act applies, shall provide to each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), written notice—

"(1) informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance;

"(2) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and

"(3) if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

"(b) EFFECTIVE DATE.—Subsection (a) shall take effect with respect to employers in a State beginning on March 1, 2013.".

SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

"(a) LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.— If—

"(1) any applicable large employer fails to offer to its fulltime employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

"(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

"(b) LARGE EMPLOYERS WITH WAITING PERIODS EXCEEDING 30 DAYS.—

"(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to enroll in any minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment, in the amount specified in paragraph (2), for each full-time employee of the employer to whom the extended waiting period applies.

"(2) AMOUNT.—For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is—

"(A) in the case of an extended waiting period which exceeds 30 days but does not exceed 60 days, $400, and

"(B) in the case of an extended waiting period which exceeds 60 days, $600.

"(3) EXTENDED WAITING PERIOD.—The term 'extended waiting period' means any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) which exceeds 30 days.

"(c) LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.—

"(1) IN GENERAL.—If—

"(A) an applicable large employer offers to its fulltime employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

"(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 400 percent of the applicable payment amount.

"(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) APPLICABLE PAYMENT AMOUNT.—The term 'applicable payment amount' means, with respect to any month, 1⁄12 of $750.

"(2) APPLICABLE LARGE EMPLOYER.—

"(A) IN GENERAL.—The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

"(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

"(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—

"(I) the employer's workforce exceeds 50 fulltime employees for 120 days or fewer during the calendar year, and

"(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

"(ii) DEFINITION OF SEASONAL WORKERS.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

"(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

"(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

"(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(iii) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

"(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—The term 'applicable premium tax credit and cost-sharing reduction' means—

"(A) any premium tax credit allowed under section 36B, "(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

"(C) any advance payment of such credit or reduction under section 1412 of such Act.

"(4) FULL-TIME EMPLOYEE.—

"(A) IN GENERAL.—The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.

"(B) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

"(5) INFLATION ADJUSTMENT.—

"(A) IN GENERAL.—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b)(2) and (d)(1) shall be increased by an amount equal to the product of—

"(i) such dollar amount, and

"(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

"(B) ROUNDING.—If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

"(6) OTHER DEFINITIONS.—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

"(7) TAX NONDEDUCTIBLE.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

"(e) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) TIME FOR PAYMENT.—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

"(3) COORDINATION WITH CREDITS, ETC..—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

"Sec. 4980H. Shared responsibility for employers regarding health coverage.".

(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS' WAGES.—

(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

SEC. 1514. REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart D of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986, as added by section 1502, is amended by inserting after section 6055 the following new section:

“SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON HEALTH INSURANCE COVERAGE.

“(a) IN GENERAL.—Every applicable large employer required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

“(b) FORM AND MANNER OF RETURN.—A return is described in this subsection if such return—

“(1) is in such form as the Secretary may prescribe, and

“(2) contains—

“(A) the name, date, and employer identification number of the employer,

“(B) a certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)),

“(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—

“(i) the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage, "(ii) the months during the calendar year for which coverage under the plan was available,

"(iii) the monthly premium for the lowest cost option in each of the enrollment categories under the plan, and

"(iv) the applicable large employer's share of the total allowed costs of benefits provided under the plan,

"(D) the number of full-time employees for each month during the calendar year,

"(E) the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans, and

"(F) such other information as the Secretary may require.

"(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

"(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each full-time employee whose name is required to be set forth in such return under subsection (b)(2)(E) a written statement showing—

"(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

"(B) the information required to be shown on the return with respect to such individual.

"(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(d) COORDINATION WITH OTHER REQUIREMENTS.—To the maximum extent feasible, the Secretary may provide that—

"(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

"(2) in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required under this section with the return and statement required to be provided by the issuer under section 6055.

"(e) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of any applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

"(f) DEFINITIONS.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.".

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions), as amended by section 1502, is amended by striking "or" at the end of clause (xxiii), by striking "and" at the end of clause (xxiv) and inserting "or", and by inserting after clause (xxiv) the following new clause:

> "(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and".

(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking "or" at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting ", or" and by inserting after subparagraph (GG) the following new subparagraph:

> "(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).".

(c) CONFORMING AMENDMENT.—The table of sections for subpart D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end the following new item:

"Sec. 6056. Large employers required to report on health insurance coverage.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after December 31, 2013.

SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS.

(a) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

> "(3) CERTAIN EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS NOT QUALIFIED.—
>
> > "(A) IN GENERAL.—The term 'qualified benefit' shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.
> >
> > "(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.— Subparagraph (A) shall not apply with respect to any employee if such employee's employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.".

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 of such Code is amended—

(1) by striking "For purposes of this section, the term" and inserting "For purposes of this section—

"(1) IN GENERAL.—The term", and

(2) by striking "Such term shall not include" and inserting the following:

"(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term 'qualified benefit' shall not include".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking "or" at the end of subclause (VI);

(B) by adding "or" at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

"(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);".

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

"(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.".

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

(i) in paragraph (24), by striking "or" at the end;

(ii) in paragraph (25), by striking the period and inserting "; or"; and

(iii) by adding at the end the following:

"(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).".

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting "subsection (y) and" before "section 1933(d)"; and

(B) by adding at the end the following new subsection:

"(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

"(1) AMOUNT OF INCREASE.—

"(A) 100 PERCENT FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent.

"(B) 2017 AND 2018.—

"(i) IN GENERAL.—During the period that begins on January 1, 2017, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point increase specified in clause (ii) for the quarter and the State.

"(ii) APPLICABLE PERCENTAGE POINT INCREASE.—

"(I) IN GENERAL.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

"For any fiscal year quarter occurring in the calendar year:	If the State is an expansion State, the applicable percentage point increase is:	If the State is not an expansion State, the applicable percentage point increase is:
2017	30.3	34.3
2018	31.3	33.3

"(II) EXPANSION STATE DEFINED.—For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

"(C) 2019 AND SUCCEEDING YEARS.—Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.

"(D) LIMITATION.—The Federal medical assistance percentage determined for a State under subparagraph (B) or (C) shall in no case be more than 95 percent.

"(2) DEFINITIONS.—In this subsection:

"(A) NEWLY ELIGIBLE.—The term 'newly eligible' means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

"(B) FULL BENEFITS.—The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).".

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

"(2) Beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

"(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.".

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking "and (XIV)" and inserting "(XIV)" and by inserting "and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)" before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking "100" and inserting "133".

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xii);

(ii) by inserting "or" at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

"(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),".

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(i)(VIII)," after "1902(a)(10)(A)(i)(VII),".

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u– 7(a)(1)(B)) is amended by inserting "subclause (VIII) of section 1902(a)(10)(A)(i) or under" after "eligible under".

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking "and" at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting "; and"; and

(C) by inserting after paragraph (73) the following new paragraph:

"(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg)."; and

(2) by adding at the end the following new subsection: "(gg) MAINTENANCE OF EFFORT.—

"(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable

Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

"(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

"(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

"(4) DETERMINATION OF COMPLIANCE.—

"(A) STATES SHALL APPLY MODIFIED GROSS INCOME.— A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).".

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each";

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)" after "subsection (a)(1),";

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses

(vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services."; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

"(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

"(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).".

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking "and" at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting "; and"; and

(C) by inserting after paragraph (74) the following new paragraph:

"(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

"(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

"(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

"(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.".

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.— Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking "or" at the end;

(ii) in subclause (XIX), by adding "or" at the end; and

(iii) by adding at the end the following new subclause:

"(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);" and

(B) by adding at the end the following new subsection:

"(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xiii);

(ii) by inserting "or" at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

"(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),".

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(ii)(XX)," after "1902(a)(10)(A)(ii)(XIX),".

(C) Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by subsection (a)(4)(B), is amended by inserting "or clause (ii)(XX)" after "clause (i)(VIII)".

SEC. 2002. INCOME ELIGIBILITY FOR NONELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

"(14) INCOME DETERMINED USING MODIFIED GROSS INCOME.—

"(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

"(B) NO INCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

"(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

"(D) EXCEPTIONS.—

"(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

"(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

"(II) Individuals who have attained age 65.

"(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

"(IV) Individuals described in subsection (a)(10)(C).

"(V) Individuals described in any clause of subsection (a)(10)(E).

"(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

"(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—

Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

"(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

"(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

"(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

"(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

"(G) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms 'modified gross income' and 'household income' have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

"(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

> "(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual's

income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

"(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.".

(b) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting "(e)(14)," before "(l)(3)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2014.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting "or the care and services themselves, or both" before "(if provided in or after".

RESPONDENT'S BRIEF

Nos. 11-393 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.

STATES OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

*ON PETITIONS FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT*

CONSOLIDATED BRIEF FOR RESPONDENTS

DONALD B. VERRILLI, JR.
Solicitor General
Counsel of Record

TONY WEST
Assistant Attorney General

MARK B. STERN
ALISA B. KLEIN
SAMANTHA L. CHAIFETZ
DANA KAERSVANG
Attorneys

Department of Justice
Washington, D.C. 20530-0001
SupremeCtBriefs@usdoj.gov
(202) 514-2217

QUESTIONS PRESENTED

Petitioners challenge the constitutionality of certain provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, and urge, further, that none of the Act's provisions could be severed from the Act's minimum coverage provision if that provision were invalidated. The questions presented are:

1. Whether the provision of the Act that expands eligibility for Medicaid to cover individuals with income up to 133% of the federal poverty level, 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII), is a valid exercise of Congress's power to set the terms on which it will appropriate federal funds. (No. 11-400 only)

2. Whether the provision of the Act that, under certain circumstances, establishes penalties for large employers that do not offer adequate health insurance coverage to full-time employees, 26 U.S.C.A. 4980H, is constitutional as applied to state employers. (No. 11-400 only)

3. Whether other provisions of the Act could be severed from the Act's minimum coverage provision, 26 U.S.C.A. 5000A, if that provision were found to be unconstitutional.

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OPINIONS BELOW

The opinion of the court of appeals (App. 1a-273a[1]) is reported at 648 F.3d 1235. The district court's opinion on the federal government's motion to dismiss (App. 394a-475a) is reported at 716 F. Supp. 2d 1120. The district court's opinion on the parties' cross-motions for summary judgment (App. 274a-368a) is reported at 780 F. Supp. 2d 1256. The district court's opinion entering a stay of its declaratory judgment (App. 369a-393a) is reported at 780 F. Supp. 2d 1307.

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[1] Cites are to the appendix to the federal government's petition for a writ of certiorari in *Department of Health & Human Services* v. *Florida*, No. 11-398 (filed Sept. 28, 2011).

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2011. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act or Act),[2] to address a profound and enduring crisis in the market for health care, which accounts for more than 17% of the Nation's gross domestic product. Millions of people do not have health insurance and thus consume health care services for which they do not pay, shifting billions of dollars of health care costs to other market participants. The result is higher health insurance premiums that, in turn, make health insurance unaffordable to even greater numbers of people. At the same time, insurance companies use restrictive underwriting practices to deny coverage or charge more to millions of people because of pre-existing medical conditions.

In the Affordable Care Act, Congress addressed these problems through a comprehensive program of economic regulation and tax measures. The Act includes provisions designed to make affordable health insurance more widely available, to protect consumers from restrictive insurance underwriting practices, and to reduce the amount of uncompensated medical care.

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[2] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

First, the Act builds upon the existing nationwide system of employer-based health insurance that is the principal private mechanism for financing health care. The Act creates new tax incentives for small businesses to purchase health insurance for their employees, 26 U.S.C.A. 45R,[3] and, under certain circumstances, imposes assessable payments on large employers that do not offer adequate coverage to full-time employees, 26 U.S.C.A. 4980H (the employer responsibility provision).[4]

Second, the Act provides for the creation of health insurance exchanges to allow individuals, families, and small businesses to leverage their collective buying power to obtain health insurance at rates that are competitive with those of typical large employer group plans. 42 U.S.C.A. 18031. The Act also establishes federal tax credits to assist eligible households with incomes from 133% to 400% of the federal poverty level to purchase insurance through the exchanges. 26 U.S.C.A. 36B.

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[3] Because the Affordable Care Act has not yet been codified in the United States Code, this brief cites to the United States Code Annotated (U.S.C.A.) for ease of reference. All such citations are either to the 2011 Edition or the 2011 Supplement to the U.S.C.A.

[4] Subject to certain exceptions, the provision (which will take effect in 2014) will apply to all employers that employ an average of at least 50 full-time equivalent employees during the preceding calendar year. 26 U.S.C.A. 4980H(c)(2)(A) & (E); 26 U.S.C.A. 4980H note. Such an employer will be required to make an assessable payment if it "fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan," and at least one of its full-time employees has enrolled in a qualified health plan purchased on an exchange "with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee." 26 U.S.C.A. 4980H(a)(1) and (2). Such a large employer is also subject to making an assessable payment if it offers coverage but one or more of its full-time employees receive a tax credit or cost-sharing reduction for coverage on an exchange because the employer-provided coverage is not affordable or because the employer pays for less than 60% of the total allowed costs of benefits provided under the plan. 26 U.S.C.A. 36B(c)(2)(C), 4980H(b)(1).

Third, the Act extends eligibility for Medicaid to individuals under age 65 with incomes up to 133% of the federal poverty level. 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII) (Medicaid eligibility expansion). The Act provides that the federal government will pay 100% of the expenditures required to cover these newly eligible Medicaid recipients through 2016. 42 U.S.C.A. 1396d(y)(1). The federal government's share thereafter will decline slightly and level off at 90% in 2020 and beyond—far above the usual federal matching rates for Medicaid. Compare *ibid.* with 42 U.S.C.A. 1396d(b) (50% to 83%).

Fourth, the Act regulates insurers to prohibit industry practices that have prevented individuals from obtaining and maintaining health insurance. The Act will bar insurers from refusing coverage because of a preexisting medical condition, 42 U.S.C.A. 300gg-1(a), 300gg-3(a) (the guaranteed-issue provision), thereby guaranteeing access to insurance for many previously unable to obtain it. The Act also bars insurers from charging higher premiums based on a person's medical history, 42 U.S.C.A. 300gg (the community-rating provision), requiring instead that premiums generally be based on community-wide criteria.

Fifth, the Act amends the Internal Revenue Code to provide that a non-exempted individual who fails to maintain a minimum level of health insurance coverage must pay a tax penalty. 26 U.S.C.A. 5000A (the minimum coverage provision).

2. a. Petitioners in No. 11-393 are two individuals, Mary Brown and Kaj Ahlburg, and the National Federation of Independent Business (NFIB), of which Brown is a member. Petitioners in No. 11-400 are 24 States, a state attorney general, and a governor.

Petitioners filed suit in the Northern District of Florida, challenging the constitutionality of several provisions of the Affordable Care Act. As relevant here, all petitioners challenged the minimum coverage provision as beyond Congress's Article I powers. The state petitioners asserted constitutional challenges both to the Medicaid eligibility expansion, and to the employer responsibility provision as applied to the state petitioners as large employers. All petitioners also argued that if the minimum coverage provision were found to be unconstitutional, the whole Act should be invalidated.

b. The district court held that the minimum coverage provision is not a valid exercise of Congress's Article I powers. App. 278a n.4, 296a-350a, 401a-424a. At the same time, the court rejected petitioners' claim that the Medicaid eligibility expansion is unduly "coercive" in violation of Congress's spending power, concluding that "there is simply no support for [petitioners'] coercion argument in existing case law." App. 282a, 283a. The district court also rejected the state petitioners' challenge to the employer responsibility provision as applied to them in their capacity as large employers. App. 445a-451a.[5]

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[5] Although the federal government argued that the Anti-Injunction Act, 26 U.S.C. 7421(a), barred consideration of the state petitioners' challenge to the employer responsibility provision, see Memo. in Supp. of Fed. Govt's Mot. to Dismiss at 21-22, the district court did not

Despite having found only one provision of the Act unconstitutional, the district court declared the entire Act invalid, based on its view that conducting a "section-by-section" severability analysis would require "considerable time and extensive briefing" and that "[t]he Act, like a defectively designed watch, needs to be redesigned and reconstructed by the watchmaker." App. 361a, 363a. The district court stayed its declaratory judgment pending appellate review. App. 387a-392a.

3. The court of appeals affirmed in part and reversed in part. The panel unanimously rejected the state petitioners' challenge to the Act's expansion of Medicaid eligibility. App. 50a-63a, 189a n.1. The court concluded that, under certain circumstances, a condition on federal funds may be invalidated because it is unduly "coercive," but held that the Act's expansion of Medicaid eligibility did not run afoul of that rule. App. 60a. The court observed that Congress long ago had expressly reserved the right to alter the Medicaid program; that, since the program's inception, Congress has repeatedly enacted amendments that expanded Medicaid eligibility; and that none of those amendments has been deemed unduly coercive. App. 60a-61a & n.66. The court further emphasized that the federal government will bear nearly all of

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address that question. The federal government also argued in the district court that the Anti-Injunction Act barred consideration of petitioners' challenge to the minimum coverage provision, see *id.* at 33-34, and the district court rejected that contention, App. 401a-425a. The federal government no longer contends that the Anti-Injunction Act applies to pre-enforcement challenges to the minimum coverage provision. See note 9, *infra*.

the costs associated with the Affordable Care Act's expansion of the Medicaid program. App. 61a.[6]

The court of appeals next held that the minimum coverage provision is not a valid exercise of Congress's commerce power, App. 63a-156a, or taxing power, App. 157a-172a. The court further held, however, that the rest of the Act could be severed from the minimum coverage provision. App. 172a-186a.

As an initial matter, the court rejected the district court's conclusion that no other provision was severable from the minimum coverage provision such that "wholesale invalidation" of the Act was required. App. 174a-176a. The court of appeals then separately analyzed the severability of the guaranteed-issue and community-rating provisions, which all parties had agreed could not be severed from the minimum coverage provision. App. 176a-186a; see n.13, *infra*; States' C.A. Br. 62; NFIB C.A. Br. 60-61. The court disagreed with that shared judgment, as well as an explicit Congressional finding, and held that, even without the minimum coverage provision, the guaranteed-issue and community-rating provisions (together with other provisions of the Act) would still further the Act's "basic objective * * * to make health insurance coverage accessible and thereby to reduce the number of uninsured persons." App. 180a-186a.

Judge Marcus dissented from the majority's Commerce Clause ruling, explaining that he would uphold the minimum coverage provision as a valid exercise of Congress's commerce power. App. 189a-262a.

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[6] The court of appeals did not address the state petitioners' Tenth Amendment challenge to the employer responsibility provision in light of their express concession that the challenge was foreclosed by this Court's decision in *Garcia* v. *San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985). See States' C.A. Br. 59 n.6.

4. The federal government has filed a petition for a writ of certiorari in No. 11-398 that presents the question whether Congress had the power under Article I of the Constitution to enact the minimum coverage provision.[7]

ARGUMENT

Petitioners challenge three components of the Affordable Care Act's comprehensive scheme for addressing the crisis in the national healthcare market. First, the state petitioners challenge a provision in the Act, 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII), that will expand Medicaid eligibility to include individuals under age 65 with incomes up to 133% of the federal poverty level. See States' Pet. 16-26. Second, the state petitioners challenge the applicability to them as employers of the provision in the Act, 26 U.S.C.A. 4980H, that, under certain circumstances, will impose assessable tax payments on large employers that do not offer adequate coverage to full-time employees. See States' Pet. 26-29. Third, both sets of petitioners contend that, if the minimum coverage provision is held unconstitutional, the entire Act should be declared inseverable and invalidated. See *id.* at 29-37; NFIB Pet. 19-21. As explained below, the federal government respectfully suggests that the Court should deny review of the first two questions (Medicaid and employer responsibility) and grant review of the third question (severability).

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[7] In addition to the federal government's petition and the two petitions to which this brief responds, there are three other pending petitions presenting questions regarding the constitutionality of the minimum coverage provision and threshold questions of whether the claims can be adjudicated. See *Liberty University, Inc.* v. *Geithner*, No. 11-438 (filed Oct. 7, 2011); *Virginia* v. *Sebelius*, No. 11-420 (filed Sept. 30, 2011); *Thomas More Law Ctr.* v. *Obama*, No. 11-117 (filed July 26, 2011).

The court of appeals correctly rejected the state petitioners' challenge to the Medicaid eligibility expansion, and further review of that ruling is not warranted. No court has ever invalidated a federal funding condition on the coercion theory the state petitioners urge here. It is settled that Congress may fix the terms on which it appropriates federal funds, and since the inception of the Medicaid program, Congress has made coverage of specified categories of individuals a condition of state participation. Congress expressly reserved the right to amend the Medicaid statute, and, over the years, it has done so repeatedly to expand the categories of individuals for whom coverage under the program is mandatory. Finally, the federal government will bear nearly the entire financial burden of the Act's Medicaid eligibility expansion. That expansion does not exceed Congress's spending power.

The state petitioners' Tenth Amendment challenge to the employer responsibility provision likewise does not merit review. As an initial matter, that claim is barred by the Anti-Injunction Act, 26 U.S.C. 7421(a), which generally prohibits pre-enforcement challenges to "the assessment or collection of any tax." Even apart from that threshold barrier, review of this claim would be unwarranted. The state petitioners acknowledge that their claim is foreclosed by *Garcia* v. *San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985), and they fail to make the demanding showing this Court requires before determining that one of its precedents should be overruled. Finally, the employer responsibility provision is independently supported by Congress's Article I power to lay and collect taxes, and *Garcia* has no bearing on that separate basis of authority.

For the reasons stated in its certiorari petition, the federal government believes Congress had Article I authority to enact the minimum coverage provision. See 11-398 Pet. 14-29. In the event this Court disagrees, however, the federal government believes it would be appropriate for the Court to consider certain issues concerning whether additional provisions of the Act should be held inseverable in this case. The court of appeals correctly rejected petitioners' sweeping contention that if the minimum coverage provision were struck down as unconstitutional, the entire Affordable Care Act should be declared invalid. Most of the Act's myriad provisions have nothing to do with the minimum coverage provision, and many of them have already taken effect, demonstrating that Congress believed they could operate independently.

The court of appeals did err, however, in holding that the guaranteed-issue and community-rating provisions that will take effect in 2014 can be severed from the minimum coverage provision. As an initial matter, the court of appeals should not have reached that question at petitioners' behest because those provisions do not "burden" petitioners. *Printz* v. *United States*, 521 U.S. 898, 935 (1997). In any event, the court's conclusion that the guaranteed-issue and community-rating provisions could be severed from the minimum coverage provision was incorrect. Without the minimum coverage provision, the guaranteed-issue and community-rating provisions would not advance Congress's efforts to make affordable coverage widely available. Indeed, Congress's findings expressly recognized the integral relationship between those provisions. 42 U.S.C.A. 18091(a)(2)(I). Because of the importance of severability issues in this case, the

Court should grant the States' petition limited to question three, and also grant NFIB's petition.

1. The court of appeals correctly rejected the state petitioners' contention that the Affordable Care Act's expansion of Medicaid eligibility is unconstitutionally coercive (Pet. 16-26), and that ruling does not conflict with any decision of this Court or any other court of appeals. Further review is unwarranted.

a. Medicaid "is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). "Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the [statutory] requirements." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980).

To be eligible for federal funds, a participating State must submit a plan to the Department of Health and Human Services (HHS) demonstrating that the State is in compliance with the Medicaid Act's requirements. 42 U.S.C.A. 1396a. Since the inception of the program in 1965, the Medicaid Act has specified categories of individuals to whom state programs must provide medical assistance, as well as the kinds of medical care and services the programs must cover. See *Pharmaceutical Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 650-651 & n.4 (2003). For example, the Medicaid Act requires state programs to make medical assistance available to low-income families with dependent children and to low-income individuals who are elderly, blind, or disabled. 42 U.S.C.A. 1396a(a)(10)(A)(i). The Medicaid Act also requires state programs to cover specified benefits for Medicaid enrollees. 42 U.S.C.A. 1396a(a)(10).

If the Secretary of HHS approves a state plan, the federal government reimburses a percentage of most Medicaid expenses the State incurs. That percentage ranges from 50% to 83%, depending on the State's per capita income. 42 U.S.C.A. 1396d(b).

From the outset, Congress reserved the "right to alter, amend, or repeal any provision" of the Social Security Act, 42 U.S.C. 301 *et seq.* (of which the Medicaid Act is a part). 42 U.S.C. 1304; *Bowen* v. *Public Agencies Opposed to Soc. Sec. Entrapment*, 477 U.S. 41, 44 (1986) (*Public Agencies*). With this "language of reservation," Congress gave "special notice of its intention to retain[] full and complete power to make such alterations and amendments as come within the just scope of legislative power." *Id.* at 53 (quoting *Sinking-Fund Cases*, 99 U.S. 700, 720 (1879)). The reservation clause "makes express what is implicit in the institutional needs of the program" —that "it was inevitable that amendment of its provisions would be necessary in response to evolving social and economic conditions." *Id.* at 51-52 (quoting *Flemming* v. *Nestor*, 363 U.S. 603, 611 (1960)). Accordingly, each State has signed a Medicaid plan that includes an express statement that the plan "will be amended whenever necessary to reflect new or revised Federal statutes." *E.g.*, Florida Agency for Health Care Admin., *State Plan Under Title XIX of the Social Security Act Medical Assistance Program* § 7.1, at 86 (Oct. 6, 1992); see 42 C.F.R. 430.12(c)(1)(i) (requiring all States participating in Medicaid to include such provisions in their plans).

Congress has amended the Medicaid Act many times. As a result, between 1966 and 2008, Medicaid enrollment increased from four million to 47.6 million recipients. Centers for Medicare & Medicaid Servs., HHS, *2010 Ac-*

tuarial Report on the Financial Outlook for Medicaid 19 Tbl. 3 (Dec. 21, 2010). For example, in 1972, Congress required participating States to extend Medicaid to recipients of Supplemental Security Income, thereby significantly expanding Medicaid enrollment. Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329. In 1989, Congress again expanded enrollment by requiring States to extend Medicaid to pregnant women and children under age six who meet certain income limits. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, Tit. VI, Subtit. B, 103 Stat. 2258; see 42 U.S.C.A. 1396a note (listing amendments).

b. In the Affordable Care Act, Congress expanded Medicaid eligibility to include individuals under age 65 with incomes up to 133% of the federal poverty level. 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII). The federal government will bear nearly the entire cost of coverage for newly eligible individuals. From 2014 through 2016, the federal government will pay 100% of the costs associated with the expansion. 42 U.S.C.A. 1396d(y). That amount will gradually decrease, to 95% in 2017, 94% in 2018, and 93% in 2019. *Ibid.* In 2020 and thereafter, the federal government will continue to pay 90% of these costs. *Ibid.*

The state petitioners provide no basis to invalidate these amendments to the Medicaid program. "The Constitution empowers Congress to 'lay and collect Taxes, Duties, Imposts, and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States.'" *South Dakota* v. *Dole*, 483 U.S. 203, 206 (1987) (quoting U.S. Const. Art. I, § 8, Cl. 1). "Incident to this power, Congress may attach conditions on the receipt of federal funds, and has repeatedly employed the power 'to further broad policy objectives by conditioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives.'" *Ibid.* (citations omitted). It is thus settled that Congress may "fix the terms on which it shall disburse federal money to the States." *New York* v. *United States*, 505 U.S. 144, 158 (1992) (quoting *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981)).

This Court has identified four general constraints on Congress's spending power. First, conditions attached by Congress on the expenditure of federal funds must promote the general welfare. *Dole*, 483 U.S. at 207. Second, conditions on a State's receipt of federal funds must be unambiguous. *Ibid.* Third, the Court has "suggested (without significant elaboration) that conditions on federal grants might be illegitimate if they are unrelated 'to the federal interest in particular national projects or programs.'" *Ibid.* (citation omitted). Fourth, no condition attached to receipt of federal funds may violate other provisions of the Constitution. *Id.* at 208.

"The state [petitioners] do not contend that the Act's Medicaid expansion violates any of these restrictions." App. 53a. They also do not dispute that participation in Medicaid is voluntary and that States are permitted to withdraw from the program. *Virginia Hosp. Ass'n*, 496 U.S. at 502; *McRae*, 448 U.S. at 301. Nor do they deny that they "accepted" participation in Medicaid "under an Act that contained * * * language of reservation," *i.e.*, 42 U.S.C. 1304, "expressly notif[ying] [them] that Congress retained the power to amend the law." *Public Agencies*, 477 U.S. at 54. Nonetheless, the state petitioners point to this Court's statement in *Dole* that "in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" States' Pet. 17 (quoting 483 U.S. at 211). They then assert that federal Medicaid funding is so generous that it would be very difficult for them to stop accepting it, and that Congress may therefore no longer establish the terms on which it appropriates Medicaid funds. See *id.* at 22.

Every court of appeals to consider such coercion challenges—even where a State's entire federal Medicaid grant was potentially at stake—has rejected them. App. 58a ("[O]ur review of the relevant case law indicates that no court has ever struck down a law such as this one as unduly coercive."); see *California* v. *United States*, 104 F.3d 1086, 1092 (9th Cir.), cert. denied, 522 U.S. 806 (1997); *Padavan* v. *United States*, 82 F.3d 23, 29 (2d Cir. 1996); *Oklahoma* v. *Schweiker*, 655 F.2d 401, 405-411 (D.C. Cir. 1981). The courts of appeals have likewise consistently rejected coercion claims with respect to other federal spending programs in which loss of all federal funding was a possible consequence of state noncompliance. See, *e.g.*, *Van Wyhe* v. *Reisch*, 581 F.3d 639, 652 (8th Cir. 2009) (entire federal grant for state prisons), cert. denied, 130 S. Ct. 3323 (2010), and 131 S. Ct. 2149 (2011); *Jim C.* v. *United States*, 235 F.3d 1079, 1082 (8th Cir. 2000) (entire federal education grant), cert. denied, 533 U.S. 949 (2001); *Kansas* v. *United States*, 214 F.3d 1196, 1198, 1201-1202 (10th Cir.) (entire federal welfare grant), cert. denied, 531 U.S. 1035 (2000); see also *Nevada* v. *Skinner*, 884 F.2d 445, 448-449 (9th Cir. 1989) (95% of federal highway grant), cert. denied, 493 U.S. 1070 (1990).

The state petitioners rely (Pet. 18-20) on Judge Luttig's plurality opinion in *Virginia Department of Education* v. *Riley*, 106 F.3d 559 (4th Cir. 1997) (en banc) (per curiam), which suggested, in *dicta*, that there would be a "substantial constitutional question," *id.* at 561, whether it would be impermissibly coercive for a federal agency to withhold a State's $60 million education grant because of a failure to provide educational services to 126 of the State's 128,000 special education students, *id.* at 569. In a later case, the Fourth Circuit recognized that Judge Luttig's "analysis, of course, cannot be viewed as the holding of the court in *Riley* given that [his] Tenth Amendment analysis was not necessary to the disposition of the case" and also given that Judge Luttig's Tenth Amendment discussion "represented the views of only" a minority of the en banc court. *West Virginia* v. *HHS*, 289 F.3d 281, 290-291 (4th Cir. 2002). In that same *West Virginia* case, the Fourth Circuit rejected a coercion challenge to a Medicaid provision. *Id.* at 291-297.

In any event, the state petitioners' coercion claim would fail even under Judge Luttig's analysis. He opined that a valid Tenth Amendment claim would lie where the federal government "withholds the entirety of a substantial federal grant on the ground that the States refuse to fulfill their federal obligation in some *insubstantial* respect." *Riley*, 106 F.3d at 570 (emphasis added). The Affordable Care Act's amendments to the Medicaid program are in no sense "insubstantial"; to the contrary, the state petitioners acknowledge that they are "core program requirements." States' Pet. 26. The Act's Medicaid expansion is expected to provide health care coverage to more than 16 million individuals, see *CBO's March 2011 Estimate of the Effects of Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act* 1 (Mar. 18, 2011), and concerns the very contours of the Medicaid program—its basic eligibility requirements. If Congress could not define the basic features of the cooperative spending programs it offers to the States, it could no longer "fix the terms on which it shall disburse federal money to the States." *New York*, 505 U.S. at 158 (internal citation omitted). The States could instead insist upon receiving federal funds on their own terms, contrary to the Constitution's express grant of exclusive authority over appropriations to Congress. See Art. I, § 9, Cl. 7; *OPM* v. *Richmond*, 496 U.S. 414, 424-425 (1990).

Contrary to the state petitioners' suggestion (Pet. 6, 21), the structure of the Affordable Care Act amendments to Medicaid does not differ materially from the structure of the prior Medicaid amendments extending eligibility to recipients of Supplemental Security Income in 1972 and to low-income pregnant women and children under age six in 1989. See p. 13, *supra*. Under those amendments, as under the Affordable Care Act amendments, state coverage of the newly eligible individuals was a condition of a State's continued participation in the Medicaid program.[8]

The state petitioners suggest that the Court grant review in order to correct those courts of appeals that, in the state petitioners' view, have concluded that "the coercion doctrine is not viable or does not exist." Pet. 18

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[8] While the state petitioners have sought to have the Affordable Care Act's expansion of Medicaid eligibility declared unconstitutional, other state officials have defended the expansion "as an affordable and preferable alternative to the costs that their states would have faced, without any federal assistance, to underwrite health insurance for poor, childless adults or to subsidize uninsured care for such populations." Dist. Ct. Amicus Br. of the Governors of Wash., Colo., Mich., & Pa. 13 (Docket No. 133); see also Dist. Ct. Amicus Br. of Or., Iowa, Vt., Md., & Ky. at 7-8 (Docket No. 130) ("By seeking to block the expansion of Medicaid coverage, [petitioners] are trying to achieve their policy preferences through litigation at the expense of states that want Medicaid expanded and that worked through the democratic process to achieve that policy goal at the national level.").

(quoting App. 59a). This case would not provide an appropriate vehicle for consideration of that question. The court of appeals here criticized those same courts and expressly held that there *is* a judicially enforceable coercion limitation on Congress's spending power. App. 59a-60a. It simply held that the state petitioners had failed to establish their claim of impermissible coercion—in which they challenge the basic contours of the federal funding program Congress has offered. App. 60a-63a.

2. The state petitioners' Tenth Amendment challenge to the employer responsibility provision (Pet. 26-29) likewise does not merit review.

a. As an initial matter, the Anti-Injunction Act bars the state petitioners' request for pre-enforcement review of the employer responsibility provision. That Act, with express exceptions not relevant here, provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." 26 U.S.C. 7421(a). The purpose of the Anti-Injunction Act is to preserve the government's ability to assess and collect taxes with "a minimum of preenforcement judicial interference, and to require that the legal right to the disputed sums be determined in a suit for refund." *Bob Jones University* v. *Simon*, 416 U.S. 725, 736 (1974) (internal quotation marks and citation omitted). The Anti-Injunction Act, when applicable, bars any suit seeking relief that "would necessarily preclude" the assessment or collection of taxes under the Internal Revenue Code, regardless of the plaintiff's professed motivation for the suit. *Id.* at 731-732.

Pre-enforcement review of the employer responsibility provision is prohibited by the Anti-Injunction Act.

That provision, under specified circumstances, imposes an "assessable payment" under the Internal Revenue Code on large employers that do not offer their full-time employees adequate health insurance. See 26 U.S.C.A. 4980H(a); see also 26 U.S.C.A. 4980H(b). The Affordable Care Act expressly refers to that assessable payment as a "tax." 26 U.S.C.A. 4980H(b)(2) and (c)(7).[9] If successful, the state petitioners' pre-enforcement challenge "would necessarily preclude" the assessment and collection of that tax; the challenge is therefore barred by the Anti-Injunction Act. *Bob Jones University*, 416 U.S. at 731-732. The state petitioners may pay the tax and then pursue refund actions in order to assert their Tenth Amendment challenge. See 26 U.S.C. 7422.

The state petitioners contend that the Anti-Injunction Act does not bar their separate challenge to the minimum coverage provision because "they are not taxpayers subject" to it. States' Pet. 37 n.3. Whatever the force of that contention with respect to the minimum coverage provision, it is not relevant here because the States *are* subject to the employer responsibility provision and therefore may assert their claim in a refund action. The state petitioners also asserted in the district court that they are not "person[s]" whose pre-enforcement suits are barred by the Anti-Injunction Act. Pls. Dist. Ct. Memo. in Opp. to Defs.' Mot. to Dismiss 22 (Docket No. 68). That contention is incorrect. See *Ohio* v. *Helvering*, 292 U.S. 360, 370-371 (1934) ("We find no merit in the * * * contention that a state is not embraced within the meaning of the word 'person,' as used in" a provision of the Internal Revenue Code); see also *Jefferson County Pharm. Ass'n* v. *Abbott Labs.*, 460 U.S. 150, 154-155 & n.10 (1983). From 1867 to 1966, the Anti-Injunction Act provided simply that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court," without any use of the word "person." *Bob Jones University*, 416 U.S. at 731-732 n.6 (emphasis omitted) (quoting 26 U.S.C. 7421(a) (1964)). Congress added the phrase beginning with "by any person" in 1966, not to narrow the Anti-Injunction Act, but to make clear that it *extended* to third parties. *Ibid*. The addition of this phrase thus "reaffirm[ed] the plain meaning of the original language of the Act," *Alexander* v. *"Americans United" Inc.*, 416 U.S. 752, 760 n.11 (1974), and that plain meaning encompasses state taxpayers.

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[9] In this respect, the employer responsibility provision is distinct from the minimum coverage provision, 26 U.S.C.A. 5000A, which consistently refers to the exaction it imposes for failure to maintain minimum essential coverage as a "penalty." Because only certain "penalties" are deemed "taxes" for purposes of the Anti-Injunction Act, the federal government has argued that pre-enforcement challenges to the minimum coverage provision are not barred. See Fed. Gov't Supplemental Br. at 2-9, *Liberty University, Inc.* v. *Geithner*, No. 10-2347, 2011 WL 3962915 (4th Cir. Sept. 8, 2011), petition for cert. pending, No. 11-438 (filed Oct. 7, 2011); accord *Liberty University*, 2011 WL 3962915, at *24 (Davis, J., dissenting); *Thomas More Law Ctr.* v. *Obama*, 651 F.3d 529, 539-540 (6th Cir. 2011), petition for cert. pending, No. 11-117 (filed July 26, 2011). That analysis is inapposite here, given that Congress expressly referred to the "assessable payment" in the employer responsibility provision as a "tax." 26 U.S.C.A. 4980H(b)(2) and (c)(7). Accordingly, the federal government believes that the Fourth Circuit erred when it concluded that the Anti-Injunction Act bars pre-enforcement challenges to the minimum coverage provision, but correctly determined that it bars pre-enforcement challenges to the employer responsibility provision. See *Liberty University*, 2011 WL 3962915, at *4-*14.

In any event, the court of appeals did not address the state petitioners' contention that States are not "person[s]" for purposes of the Anti-Injunction Act, and no other court of appeals has done so either. For that reason, and because this Court would need to resolve that novel threshold question in the first instance, there is a substantial reason at the outset not to accept review of the state petitioners' challenge to the employer responsibility provision.[10]

b. Even apart from the Anti-Injunction Act bar, the state petitioners' challenge to the employer responsibility provision would not merit review. The state petitioners acknowledge that in order for them to prevail on this claim the Court would have to overrule its decision in *Garcia*. See States' Pet. 29. "[E]ven in constitutional cases," *stare decisis* "carries such persuasive force" that the Court has "always required a departure from precedent to be supported by some 'special justification.'" *United States* v. *IBM Corp.*, 517 U.S. 843, 856 (1996) (brackets in original) (citation omitted). No such special justification is present here.

In *National League of Cities* v. *Usery*, 426 U.S. 833 (1976), this Court held that "the Commerce Clause [did] not empower Congress to enforce the minimum-wage and overtime provisions of the Fair Labor Standards Act * * * against the States 'in areas of traditional governmental functions.'" *Garcia*, 469 U.S. at 530 (quoting *National League of Cities*, 426 U.S. at 852). At the same time, the Court in *National League of Cities* noted that Congress continued to have the power under the Commerce Clause to regulate state functions that were not traditionally "regarded as integral parts of their governmental activities." 426 U.S. at 854 n.18; see *id.* at 851. In the years after that decision, the courts found it "difficult, if not impossible, to identify an organizing principle" that could reliably identify whether state functions were "traditional" under the *National League of Cities* standard. *Garcia*, 469 U.S. at 538-539. The Court in *Garcia* thus abandoned the *National League of Cities* approach as "unsound in principle and unworkable in practice" and held that Congress has power under the Commerce Clause to apply employment laws to both private and state employers. *Id.* at 546, 554.

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[10] To the extent the state petitioners seek to challenge the Affordable Care Act provision that will require large employers to provide for automatic enrollment of their employees in a health insurance plan "[i]n accordance with regulations promulgated by" the Department of Labor, 29 U.S.C.A. 218a; see States' Pet. 7-8 (citing Affordable Care Act § 1511, 124 Stat. 252), that challenge would be premature. The Department of Labor has explained that compliance with that provision will not be required until it issues implementing regulations, which it intends to do by 2014. Employee Benefits Sec. Admin., U.S. Dep't of Labor, *FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation* 2 (Dec. 22, 2010). "The Department of Labor expects to work with stakeholders to ensure that it has the necessary information and data it needs to develop regulations in this area that take into account the practices employers currently use for auto-enrollment and to solicit the views and practices of a broad range of stakeholders, including employers, workers, and their families." *Ibid.* Review by this Court would be unwarranted until the features of this requirement are fully established.

In seeking a return to the approach of *National League of Cities*, the state petitioners offer no clues as to how they would define the "areas of traditional governmental functions" (426 U.S. at 852) that would be immune from regulation under the Commerce Clause. Given that it was the lack of any workable standard on precisely that question that in large part led the Court to abandon *National League of Cities*, see *Garcia*, 469 U.S. at 531, 537-540, the state petitioners' silence fatally weakens their request to overrule *Garcia*.

State petitioners likewise make no effort to show that they would prevail under the approach of *National League of Cities*. Not all state employees work in "areas of traditional governmental functions" (however that category is defined). *National League of Cities*, 426 U.S. at 852. The state petitioners also fail to demonstrate that the employer responsibility provision would require them to "substantially restructure traditional ways in which [they] have arranged their affairs." *Id.* at 849. Finally, the state petitioners fail to acknowledge that *National League of Cities* allowed for the possibility of federal regulation of state employers where, as is the case with the national health care crisis, there is "an extremely serious problem which endanger[s] the well-being of all the component parts of our federal system and which only collective action by the National Government might forestall." *Id.* at 853.

The only argument the state petitioners advance for departing from *stare decisis* and overruling *Garcia* is the purported inconsistency of its "animating reasoning" with this Court's subsequent decisions in *New York*, *supra*, and *Printz*, *supra*. Pet. 28. That contention lacks merit. *New York* and *Printz* established that the federal government cannot commandeer a State or state officials to regulate private parties on the federal government's behalf and that it must, instead, regulate private parties directly. *New York*, 505 U.S. at 149; *Printz*, 521 U.S. at 925. Neither decision called into question the reasoning of *Garcia*, which concerned a federal statute applicable to States as employers, not regulators. See, *e.g.*, *New York*, 505 U.S. at 160 ("This litigation presents no occasion to apply or revisit the holding[] of [*Garcia*], as this is not a case in which Congress has subjected a State to the same legislation applicable to private parties.").

The state petitioners' contention that *Printz* and *New York* provide support for overruling *Garcia* is also irreconcilable with *Reno* v. *Condon*, 528 U.S. 141 (2000). In that case, this Court expressly distinguished the kind of impermissible commandeering at issue in *New York* and *Printz* from direct federal regulation of a State's own activities, and the Court unanimously reaffirmed that such direct regulation presents no Tenth Amendment issue, at least where, as in *Condon* and this case, the regulation is one of general applicability. *Id.* at 149-151. *Condon* upheld the Driver's Privacy Protection Act of 1994 (DPPA), 18 U.S.C. 2721 *et seq.*, which regulates the disclosure of personal information contained in the records of state motor vehicle departments. 528 U.S. at 143. The Court explained that the statute "does not require the States in their sovereign capacity to regulate their own citizens"; it instead "regulates the States as owners of data bases." *Id.* at 151. The Court noted that the DPPA does not require the State "to enact any laws or regulations, and it does not require state officials to assist in the enforcement of federal statutes regulating private individuals." *Ibid.* Accordingly, the Court held that the statute "is consistent with the constitutional principles enunciated in *New York* and *Printz*." *Ibid.*

The same logic applies here. The employer responsibility provision regulates the States' own activities; it does not compel their regulation of private individuals. Moreover, the Court in *Reno* found it unnecessary to consider South Carolina's contention "that Congress may only regulate the States by means of 'generally applicable' laws, or laws that apply to individuals as well as States," because it concluded that the DPPA was "generally applicable." 528 U.S. at 151. Here too, the employer responsibility provision applies to large private employers just as it applies to States. In *Reno*, "[t]he DPPA regulate[d] the universe of entities that participate as suppliers to the market for motor vehicle information," *id.* at 151, and here the employer responsibility provision regulates the universe of large employers that participate in the market for labor. In neither situation does the Constitution compel an exemption for States as market participants. *Ibid.*

c. Finally, the States' petition would provide a poor vehicle for reexamination of *Garcia* because the employer responsibility provision is authorized not only by Congress's commerce power (at issue in *Garcia*) but also by its taxing power. The taxing power is "comprehensive," *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 581-582 (1937), and, in "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson* v. *Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941) (quoting *Lawrence* v. *State Tax Comm'n*, 286 U.S. 276, 280 (1932)).

The "practical operation" of the employer responsibility provision is as a tax. *Nelson*, 312 U.S. at 363. Under certain circumstances, the provision imposes an "assessable payment" on large employers that do not offer adequate health insurance coverage to their full-time employees. 26 U.S.C. 4980H(a); see also 26 U.S.C.A. 4980H(b). The provision is administered exclusively by the Internal Revenue Service, see 26 U.S.C.A. 4980H(d), and it will unquestionably be "productive of some revenue," *Sonzinsky* v. *United States*, 300 U.S. 506, 514 (1937).

Moreover, the provision is just one example of Congress's use of its taxing power to encourage employers to provide adequate health insurance. See Congressional Budget Office, *Key Issues In Analyzing Major Health Proposals* 29 (Dec. 2008); 11-398 Pet. 27-28 & n.4. The fact that Congress had a regulatory motivation in enacting the employer responsibility provision is immaterial.

A tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States* v. *Sanchez*, 340 U.S. 42, 44 (1950).

The Court should not consider whether to overrule *Garcia*'s holding on the Commerce Clause in a case in which such a ruling would be unnecessary to the outcome.[11]

3. The government's petition for a writ of certiorari in No. 11-398 demonstrates that the court of appeals fundamentally erred in invalidating the minimum coverage provision, which is a proper exercise of Congress's commerce power and, independently, its taxing power. In the event the Court disagrees, however, it would be appropriate for the Court to grant certiorari to determine certain issues concerning whether additional provisions of the Act may be severed from the minimum coverage provision. Accordingly, the federal government believes that the Court should grant NFIB's petition and the third question presented in the States' petition.

a. The court of appeals correctly rejected petitioners' call for "wholesale invalidation" of the Act on the asserted ground that *none* of the Act's other provisions could be severed from the minimum coverage provision. App. 174a-176a. This Court has repeatedly held that, "when confronting a constitutional flaw in a statute," a court must "try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact." *Free Enterprise Fund* v. *Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (internal quotation marks and citation omitted). "[T]he 'normal rule,'" therefore, "is that 'partial, rather than facial, invalidation is the required course' such that a 'statute may . . . be declared invalid to the extent that it reaches too far, but otherwise left intact.'" *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 329 (2006) (citation omitted). If provisions are "fully operative as a law," they must be sustained "[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid]." *Free Enterprise Fund*, 130 S. Ct. at 3161 (brackets in original) (quoting *New York*, 505 U.S. at 186).

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[11] Before the district court, the state petitioners attempted to argue that the taxes that might be imposed on them by the employer responsibility provision would violate the "inter-governmental-tax-immunity doctrine." Docket No. 68, at 58. The district court held, however, that the state petitioners had failed to plead that claim, and, in the alternative, concluded that it failed as a matter of law. App. 451a n.14. The state petitioners challenged neither determination in the court of appeals, and they have not sought review of them in their petition for a writ of certiorari.

The court of appeals correctly explained that many of the Act's provisions are "wholly unrelated" to the minimum coverage provision, such as the provision that requires employers to provide reasonable break times for nursing mothers and the one establishing an epidemiology-laboratory capacity grant program. App. 174a-175a (providing additional examples); see also States' C.A. Br. 65 n.8 (noting state petitioner Washington's concession that the Act's reauthorization of the Indian Health Care Improvement Act, 25 U.S.C. 1601 *et seq.*, was severable from the minimum coverage provision).

Moreover, many of the Act's provisions are already in effect. See HHS, *Reducing Costs, Protecting Consumers: The Affordable Care Act on the One Year Anniversary of the Patient's Bill of Rights* 1-13 (Sept. 23, 2011). For example, more than 20 sections of the Act made changes to Medicare payment rates for 2011. Those revisions have been incorporated through notice-and-comment rulemaking into Medicare payment regulations and implemented through changes to nearly every major Medicare claims processing system. See 75 Fed. Reg. 73,170 (Nov. 29, 2010); 75 Fed. Reg. 71,800 (Nov. 24, 2010); 75 Fed. Reg. 50,042 (Aug. 16, 2010). In addition, the Act already requires insurers that provide coverage for adult children to continue making such coverage available until the young adult turns 26. 42 U.S.C.A. 300gg-14; see Office of the Asst. Sec'y for Planning & Evaluation, HHS, *ASPE Issue Brief: One Million Adults Gain Health Insurance in 2011 Because of the Affordable Care Act* 1 (Sept. 21, 2011) (One million additional young adults had health insurance in the first quarter of 2011 after this provision of the Act took effect.). Petitioners cannot meet their burden of establishing that it is "evident" (*Free Enterprise Fund*, 130 S. Ct. at 3161 (citation omitted)) that, absent the minimum coverage provision, Congress would not have enacted those already-effective provisions. Congress clearly contemplated that they would properly work independently of the minimum coverage provision because they took effect three years before that provision.

In addition, many of the Act's provisions are subject to special statutory review procedures, such as the Medicare Act's special review provision, see *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000), and the Anti-Injunction Act, 26 U.S.C. 7421(a), which bars review of the Act's many tax provisions outside the context of a suit for refund. Such exclusive review provisions would preclude judicial review and invalidation of the provisions to which they apply in the context of a severability analysis in this case.

b. Absent petitioners' request for wholesale invalidation of the Act, a proper severability analysis would focus on the Act's individual provisions, and a particular provision would not be invalidated on inseverability grounds unless it was evident that Congress would not have enacted it without a minimum coverage provision. Petitioners did not attempt to make such a provision-by-provision showing before the district court or the court of appeals. Nor do they identify any such provisions (other than the guaranteed-issue and community-rating provisions discussed below) in the questions presented or bodies of their certiorari petitions.

Moreover, petitioners must demonstrate that each of the Act's provisions they contend is inseverable from the minimum coverage provision "burden[s]" them. *Printz*, 521 U.S. at 935. But the vast majority of those provisions do not regulate petitioners, instead affecting "the rights and obligations of parties not before the Court." *Ibid.* (declining to address severability where party challenging constitutionality of federal statutes was unaffected by additional provisions claimed to be inseverable); see *Davis* v. *Federal Election Comm'n*, 554 U.S. 724, 733-734 (2008) ("'[S]tanding is not dispensed in gross.' Rather, 'a plaintiff must demonstrate standing for each claim he seeks to press' and 'for each form of relief' that is sought.") (brackets in original; citations omitted).[12]

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[12] Petitioner NFIB's bald assertion that "countless provisions of the Act aggrieve NFIB and its members," Pet. 15, does not establish its ability to challenge unspecified provisions on behalf of unidentified members. See *Summers* v. *Earth Island Inst.*, 555 U.S. 488, 498 (2009). NFIB has never demonstrated that any of its members is burdened by any provision in the Act other than the minimum coverage provision.

c. Although the state petitioners are affected by the expansion of Medicaid eligibility and thus may properly raise in this case the contention that it is inseverable from the minimum coverage provision, that contention is incorrect on the merits. The Medicaid eligibility expansion plainly could function independently of the minimum coverage provision, and petitioners fail to demonstrate that it is "evident" that Congress would not have enacted it without the minimum coverage provision. As noted, that expansion is expected to provide health insurance for more than 16 million individuals. See p. 16, *supra*. Moreover, Congress has on several occasions expanded eligibility for Medicaid without enacting a minimum coverage provision, see p. 13, *supra*, demonstrating that the two provisions need not stand or fall together. See *New York*, 505 U.S. at 186 ("Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated.").

The state petitioners also have a stake in whether the employer responsibility provision is inseverable from the minimum coverage provision because it applies to them. *Printz*, 521 U.S. at 935. But they cannot press that contention as part of this pre-enforcement challenge because of the Anti-Injunction Act. See pp. 18-21, *supra*. In any event, there is no basis to conclude that the employer responsibility provision could not function without the minimum coverage provision. Congress has long used the tax code to encourage employers to provide health insurance benefits for their employees, see p. 25, *supra*, and petitioners fail to demonstrate that it is evident that Congress would not have done so in this instance absent a minimum coverage provision.

d. The court of appeals separately considered the severability of the Act's guaranteed-issue and community-rating provisions from the minimum coverage provision. App. 176a-186a. As an initial matter, petitioners (none of which is an insurance company) did not demonstrate that they were burdened by those provisions. See *Printz*, 521 U.S. at 935.[13] The court of appeals therefore should not have reached the question of the severability of those provisions at petitioners' behest, and the court of appeals' ruling that those provisions can be severed therefore should at least be vacated.

Assuming *arguendo* that the court of appeals properly reached the merits of the severability of the guaranteed-issue and community-rating provisions, it erred in finding them severable from the minimum coverage provision. Beginning in 2014, the guaranteed-issue and community-rating provisions will bar insurers from refusing to issue health insurance coverage to a person because of a pre-existing medical condition, 42 U.S.C.A. 300gg-1(a), 300gg-3(a), and from charging higher premiums based on a person's medical history, 42 U.S.C.A. 300gg. The experience of state insurance regulators demonstrated that this system of guaranteed issue and community rating would not effectively achieve affordable coverage without a minimum coverage provision that prevents individuals from exploiting the new guarantees by delaying their purchase of insurance until their medical costs outstrip the cost of health insurance premiums.

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[13] Before the court of appeals, the federal government explained that the guaranteed-issue and community-rating provisions were "integral[ly]" related to the minimum coverage provision but argued that a finding of inseverability could not be made in this case because "even when particular provisions are integrally related, a court may not address provisions that do not burden parties to the litigation." Fed. Gov't C.A. Br. 59 (citing *Printz*, 521 U.S. at 935); see Fed. Gov't C.A. Reply Br. 59.

For example, citing New Jersey's experience, Professor Uwe Reinhardt of Princeton University explained that "[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance." Uwe E. Reinhardt, *Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the House Comm. on Energy and Commerce*, 111th Cong., 1st Sess. 10 (Mar. 17, 2009). In the wake of similar legislation in New York, "[t]here was a dramatic exodus of indemnity insurers from New York's individual market." Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & L. 71, 91-92 (2000). Likewise, when Maine enacted similar legislation, most insurers withdrew from the State. *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the House Comm. on Ways and Means*, 111th Cong., 1st Sess. 117 (2009) (statement of Phil Caper, M.D., and Joe Lendvai).

Against that background, Congress expressly found that the minimum coverage provision is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C.A. 18091(a)(2)(I). The decision of the court below in this case to reject that empirical judgment of Congress—like its decision to reject Congress's empirical judgments that provide the constitutional foundation for its enactment of the minimum coverage provision—reflects an extraordinary disregard for the "traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy," *Turner Broad. Sys. Inc.* v. *FCC*, 520 U.S. 180, 196 (1997).

CONCLUSION

The Court should, in conjunction with a grant of the federal government's petition in No. 11-398, grant the petition in No. 11-400, limited to the third question presented. The petition in No. 11-400 should otherwise be denied. The Court should grant the petition in No. 11-393.

Respectfully submitted.

DONALD B. VERRILLI, JR.
Solicitor General

TONY WEST
Assistant Attorney General

MARK B. STERN
ALISA B. KLEIN
SAMANTHA L. CHAIFETZ
DANA KAERSVANG
Attorneys

OCTOBER 2011

REPLY
BRIEF

No. 11-400

In the
Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTAD, GOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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REPLY BRIEF OF PETITIONERS

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
BLAINE H. WINSHIP
Office of the Attorney General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

October 24, 2011 *(Additional Counsel Listed on Inside Cover)*

THOMAS W. CORBETT, JR.
Governor
LINDA L. KELLY
Attorney General
Commonwealth of
Pennsylvania
16th Floor
Strawberry Square
Harrisburg, PA 17120

MARTY J. JACKLEY
Attorney General
of South Dakota
1302 East Highway 14
Pierre, SD 57501

GREGORY F. ZOELLER
Attorney General of Indiana
302 West Washington Street
Indianapolis, IN 46204

SAMUEL S. OLENS
Attorney General of Georgia
40 Capitol Square, SW
Atlanta, GA 30334

MICHAEL DEWINE
Attorney General of Ohio
30 East Broad Street
17th Floor
Columbus, OH 43215

JOSEPH SCIARROTTA, JR.
General Counsel
Office of Arizona Governor
JANICE K. BREWER
TOM HORNE
Attorney General of Arizona
1700 West Washington
Street, 9th Floor
Phoenix, AZ 85007

WAYNE STENEJHEM
Attorney General
of North Dakota
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

BRIAN SANDOVAL
Governor of Nevada
State Capitol Building
101 North Carson Street
Carson City, NV 89701

JOHN J. BURNS
Attorney General of Alaska
P.O. Box 110300
Juneau, AK 99811

DEREK SCHMIDT
Attorney General of Kansas
Memorial Hall
120 SW 10th Street
Topeka, KS 66612

GREG ABBOTT
Attorney General of Texas
BILL COBB
Deputy Attorney General
for Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

ALAN WILSON
Attorney General
of South Carolina
P.O. Box 11549
Columbia, SC 29211

LUTHER STRANGE
Attorney General
of Alabama
501 Washington Avenue
Montgomery, AL 36130

BILL SCHUETTE
Attorney General
of Michigan
P.O. Box 30212
Lansing, MI 48909

ROBERT M. MCKENNA
Attorney General
of Washington
1125 Washington Street S.E.
P.O. Box 40100
Olympia, WA 98504

JON BRUNING
Attorney General
of Nebraska
KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508
(402) 471-2834

MARK L. SHURTLEFF
Attorney General of Utah
Capitol Suite #230
P.O. Box 142320
Salt Lake City, UT 84114

JAMES D. "BUDDY" CALDWELL
Attorney General
of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804

JOHN W. SUTHERS
Attorney General
of Colorado
1525 Sherman Street,
Denver, CO 80203

LAWRENCE G. WASDEN
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720

MATTHEW MEAD
Governor of Wyoming
State Capitol
200 West 24th Street
Cheyenne, WY 82002

WILLIAM J. SCHNEIDER
Attorney General of Maine
Six State House Station
Augusta, ME 04333

J.B. VAN HOLLEN
Attorney General of Wisconsin
114 East State Capitol
Madison, WI 53702

TERRY BRANSTAD
Governor of Iowa
107 East Grand Avenue
Des Moines, IA 50319

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REPLY BRIEF OF PETITIONERS

The federal government's attempts to dissuade this Court from determining the constitutionality of core provisions of the Affordable Care Act reflect a startlingly broad conception of Congress's powers that would all but eliminate the Constitution's protections against federal incursions upon state sovereignty. The federal government envisions a spending power that "would tend to nullify all constitutional limitations upon legislative power," *United States v. Butler*, 297 U.S. 1, 74 (1936), by allowing Congress to threaten to withhold billions of dollars collected from state taxpayers unless a State abides by Congress's policy judgments. It envisions a commerce power under which Congress may regulate States in the same manner that it regulates private parties, without regard for interference with essential attributes of state sovereignty. Indeed, it envisions a world where States' necessity to employ individuals to carry out sovereign functions is a toehold for treating States like any other employer. And it envisions a tax power under which Congress can achieve anything outside the commerce power by simply imposing a penalty upon States that do not bend to its will.

The Constitution does not tip the balance of power so heavily in Congress's favor, but rather "preserves the integrity, dignity, and residual sovereignty of the States." *Bond v. United States*, 131 S. Ct. 2355, 2364 (2011). As more than half the Nation's States are attesting in this unprecedented action, the challenged provisions of the ACA fail that test. The States have, at a minimum, presented this Court with substantial questions whether core provisions of the ACA effect unconstitutional incursions upon state sovereignty.

The federal government was correct about one thing in its brief in response: This Court should consider not just the constitutionality of the individual mandate, *vel non*, but also the severability question raised in the States' third question presented. But it is entirely artificial to consider how much of the ACA would survive invalidation of the individual mandate without considering the States' serious challenges to the rest of the Act. This Court should grant the States' petition in full.

1. "[I]f the Court meant what it said in [*South Dakota v. Dole*, 483 U.S. 203 (1987)]," and other cases recognizing the coercion doctrine as a limit on Congress's spending power, then 26 States have presented "a Tenth Amendment claim of the highest order." *Va. Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997) (en banc) (plurality opinion). The ACA's Medicaid expansions contravene *Dole*'s admonition that spending legislation must be voluntary "not merely in theory but in fact." *Dole*, 483 U.S. at 211–12; *see also Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937).

Indeed, if the ACA does not cross the line articulated in *Dole*, no Act of Congress ever will. Not only is the amount of funding at stake unprecedented, but Congress has conditioned preexisting funds on new requirements. Moreover, unlike in other spending programs, Congress made clear that the "conditions" are actually mandatory in fact by providing no other mechanism for the

Medicaid-eligible to comply with the individual mandate.

Accordingly, the situation is asymmetric. This Court could strike down the Medicaid expansion without endangering other spending programs, but approving this massive and pervasively coercive expansion would be the death knell of the coercion doctrine. Abandoning that doctrine would seem tantamount to abandoning the basic federalist structure of the Constitution. Virtually any otherwise impermissible imposition—including the individual mandate itself—could be imposed as a mere "condition" on massive federal spending programs. In all events, if the coercion doctrine is just a precatory exhortation to Congress, and not a judicially-enforceable limit, this Court should make that clear.

The federal government offers no persuasive reason to deny review of the States' claim. Indeed, it affirmatively undermines one of the Eleventh Circuit's efforts to minimize the coercive impact. It does not deny that Medicaid is the single largest federal-State spending program, accounting for more than 40% of all funding to States and more than $1 billion annually for most States. More important, it does not deny that a State will lose *all* that funding if it does not comply with the ACA. That concession is critical, as the Eleventh Circuit's mistaken belief that States will *not* lose all Medicaid funding if they refuse to comply was a "determinative" factor in its analysis. Pet.App.66, 68–69. Far from defending that attempt to sidestep the issue, the federal government quite clearly concedes, as it has throughout this litigation, that the "categories of individuals to whom state programs must provide medical assistance" remain a requirement with which States *must* comply "[t]o be eligible for federal funds." Resp. 11.

The federal government also does not dispute the particularly coercive manner in which the ACA operates. It does not deny that the Act holds States hostage to their earlier decisions to participate in Medicaid by attaching new conditions to billions in preexisting funding that will not finance those new terms. Nor does it deny that those funds consist of tax dollars collected from States' own residents—tax dollars that would still be collected and distributed to other States, and that a State would have no realistic means of replacing, if a State were no longer eligible to participate in Medicaid. And it does not deny that Congress recognizes that States have no choice but to comply with the ACA. In short, the federal government does not dispute that this case presents the *non plus ultra* of coercion: the threatened loss of nearly half of all federal funding, including billions in preexisting funding, unless States capitulate to Congress's demands. Nonetheless, the federal government suggests there is nothing certworthy in the approval of this unprecedentedly coercive statute. That is untenable.

Rather than admit this is an ideal vehicle for resolution of a constitutional question that has confused lower courts for decades, the federal government proceeds as if this Court has already resolved that question in its favor. It repeatedly emphasizes the Court's acknowledgement that "Congress may 'fix the terms on which it shall disburse federal money to the States,'" Resp. 14

(*quoting New York v. United States*, 505 U.S. 144, 158 (1992)), but ignores this Court's admonition that Congress may not fix those terms *coercively* by attaching them to massive federal inducements that States cannot afford to decline. *See Dole*, 483 U.S. at 211. The federal government does not even mention *Steward Machine* or other cases recognizing that doctrine, let alone attempt to reconcile *Dole*'s adjudication of a coercion claim *on the merits* with its position that the doctrine is defunct.

The federal government also places great weight on lower court decisions rejecting coercion claims, sometimes dismissively. That some Courts of Appeals have treated the doctrine of *Dole* and *Steward Machine* as defunct weighs in favor of plenary review, not against. This Court has repeatedly admonished that it is the role of this Court, not the lower courts, to determine when a doctrine embraced by this Court has become outmoded or defunct. *See Rodriguez de Quijas v. Shearson/Am. Express*, 490 U.S. 477, 484 (1989). The States believe the doctrine of *Dole* and *Steward Machine* is vital to maintaining the federalist balance. But if this Court is inclined to jettison that doctrine, it should do so only after plenary review, not by permitting the doctrine to wither on the vine through neglect by lower courts.

Although the federal government emphasizes some of the same factors relied upon by the Eleventh Circuit, it fails to explain why those factors have any bearing on whether the ACA's Medicaid expansions are coercive or whether this Court should consider that question. The federal government stresses that Congress "reserved the 'right to alter, amend, or repeal'" provisions of Medicaid. Resp. 12 (*quoting* 42 U.S.C. § 1304). But that is a non sequitur; notice that coercion may follow does not lessen the coercion. An extortionist who provides ample forewarning of his collection schedule may thereby maximize collections, but does not lessen the extortionate nature of his demands. In all events, Congress neither did nor could reserve the right to make *unconstitutional* amendments. Instead, section 1304 merely notifies States that Congress may "make such alterations and amendments *as come within the just scope of legislative power*." *Bowen v. Public Agencies Opposed to Soc. Sec. Entrapment*, 477 U.S. 41, 53 (1986) (emphasis added).

The federal government also follows the Eleventh Circuit's lead in emphasizing that it initially will pay most costs associated with the ACA's new terms. Once again, this misses the point. The States continue to contend that the federal government has dramatically understated those costs, but if all Congress had done was condition new money on new conditions, States could make a meaningful choice. That is not how the ACA works. Congress attached the new conditions not just to new money but to billions in *preexisting* Medicaid funding. Congress did so precisely because it knew States could not afford the loss of nearly half of all federal funding, and would therefore capitulate to its demands. It is that decision that renders the ACA "more akin to forbidden regulation than to permissible condition," *Riley*, 106 F.3d at 570, in violation of core federalism principles inherent in the Constitution. *See Butler*, 297 U.S. at 71 ("The power to confer or withhold unlimited benefits is the power to coerce or destroy.").

In all events, there will be time enough to explore the contours of the coercion doctrine if the Court grants review. For present purposes, it is enough that the Court has steadfastly rejected any conception of the spending power that "would tend to nullify all constitutional limitations upon legislative power." *Id.* at 74. Even if the Court were inclined to adopt the federal government's breathtakingly broad position "that Congress *should* be able to place any and all conditions it wants on the money it gives to the states, [this] Court must be the one" to jettison decades of precedent reiterating that the spending power is not an "instrument for total subversion of the governmental powers reserved to the individual states," *id.* Pet.App.65-66.

2. "Impermissible interference with state sovereignty is not within the enumerated powers of the National Government." *Bond*, 131 S. Ct. at 2366. While enforcing the limits on those enumerated powers is not always easy, the temptation for Congress to ignore those limits is too strong, and federalism "plays too vital a role in securing freedom for [the Court] to admit inability to intervene when [Congress] has tipped the scales too far." *United States v. Lopez*, 514 U.S. 549, 578 (1995) (Kennedy, J., concurring). Contrary to this Court's holding in *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985), there is no exception for legislation that treats States like any other employer. This Court has recognized as much in its Eleventh Amendment jurisprudence. *See Bd. of Tr. of Univ. of Ala. v.*

Garrett, 531 U.S. 356, 374 (2001). The Court should reconsider *Garcia* and "again assume its constitutional responsibility," 469 U.S. at 589 (O'Connor, J., dissenting), to hold unconstitutional those federal regulations that impermissibly interfere with state sovereignty.

The federal government does not and cannot refute that *Garcia* "radically departs from long-settled constitutional values and ignores the role of judicial review in our system of government." *Id.* at 561 (Powell, J., dissenting). *Garcia*'s holding reflects an unduly narrow vision of the judiciary's role in protecting state sovereignty, under which "States must find their protection from congressional regulation through the national political process" alone, rather than via judicial review as well. *South Carolina v. Baker*, 485 U.S. 505, 512 (1988). That vision cannot be reconciled with more recent decisions striking down congressional overreaching in regulating States. *See, e.g.*, *New York*, 505 U.S. at 177 (invalidating federal regulation of States as "inconsistent with the federal structure of our Government established by the Constitution"); *Printz v. United States*, 521 U.S. 898, 935 (1997) (invalidating federal regulation of States as "incompatible with our constitutional system of dual sovereignty"); *Garrett*, 531 U.S. at 374 (invalidating effort to treat States like any other employer for purposes of the ADA as inconsistent with Eleventh and Fourteenth Amendments).

The federal government instead points to *Reno v. Condon*, 528 U.S. 141 (2000), as evidence that *Garcia* has not been overruled. But that is the whole problem. *Garcia* continues to govern, but it is out of step with the Court's efforts to enforce the Constitution's structural guarantees in a host of contexts, and not simply leave matters to the political process. The argument that the Court's subsequent rejection of *Garcia*'s reasoning provides a reason to overrule it was neither pressed nor passed upon in *Condon*. That argument is being raised now—by over half the Nation's States—and the issue is ripe for consideration. Indeed, there are far better reasons to overrule *Garcia* now than there were to overrule *National League of Cities v. Usery*, 426 U.S. 833 (1976), back in *Garcia*.

The federal government identifies no persuasive reason not to do so in this case. Its reliance on the Anti-Injunction Act ("AIA") is inapposite, as the AIA does not apply to States and does not bar challenges to the employer mandates for the same reasons that it does not bar challenges to the individual mandate. *See Liberty Univ. v. Geithner*, —— F.3d ——, 2011 WL 3962915, at *26 (4th Cir. Sept. 8, 2011) (Davis, J., dissenting) (concluding that AIA does not bar challenges to individual or employer mandates). Although the federal government highlights minor linguistic differences in the penalty provisions that accompany the individual and employer mandates, Resp. 19 n.9, the States are challenging the mandates, not the penalties, and the two are distinct. Indeed, the difference between the two is particularly important when it comes to the employer mandates' application to States, because a State would not lightly disobey federal law, irrespective of the penalty, and it is an odd version of cooperative federalism that would force a State to disobey a federal law to have any avenue to challenge it.

For that reason and others articulated in the States' response in *HHS v. Florida*, No. 11-398 (at 14–15), the AIA should not be construed to reach States. Its bar against suits brought "by any person" must be read against the "longstanding presumption that 'person' does not include the sovereign." *Vt. Agency of Natural Res. v. United States*, 529 U.S. 765, 780 (2000); *see also United States v. United Mine Workers*, 330 U.S. 258, 275 (1947). Although the federal government notes that the AIA's original version did not use the term "person," that is doubly irrelevant. The Court never held that former version applicable to States. Nor could the equally general language of the earlier AIA be read to reach States in light of this Court's recognition that, "[w]hen Congress intends to alter the usual constitutional balance between the States and the Federal Government, it must make its intention to do so unmistakably clear in the language of the statute." *Raygor v. Regents of Univ. of Minn.*, 534 U.S. 533, 543 (2002); *see also Nixon v. Mo. Mun. League*, 541 U.S. 125, 132 (2004). The point is not that "person" is a term that distinctly *excludes* States, but rather that general language should not be lightly construed to *include* States, especially when the consequence would be to lump States together with non-sovereigns in ways that ignore "the integrity, dignity, and residual sovereignty of the States." *Bond*, 131 S. Ct. at 2364.

In that sense, the federal government's reading of the AIA suffers the same basic defect as its view of the Commerce Clause and *Garcia*. The federal government sees no reason for Congress to treat States differently from any other taxpayer or employer. But that disregards the Constitution's structural protections of States' unique status and residual sovereignty.

The federal government's alternative argument that the employer mandates can be justified by Congress's taxing power only underscores the appropriateness of reviewing the constitutionality of the individual mandate and the employer mandates as applied to the States in the same case. The federal government has made essentially the same arguments as to the individual mandate. *Compare* Resp. 25, *with* Pet. 27–29, *HHS v. Fla.*, No. 11-398. The States cannot be faulted for not anticipating and refuting those arguments as to the employer mandates below, as the federal government was content to rest its defense on *Garcia*. In all events, the Eleventh Circuit rejected those arguments as to the individual mandate.

Finally, it makes sense to consider the two issues together because there is a common problem with both aspects of the ACA. Given the breadth of Congress's power under this Court's modern Commerce Clause jurisprudence, one of the only ways an individual can avoid the regulatory reach of the federal government is to refrain from engaging in commerce. The individual mandate is problematic precisely because it eliminates that option. States face a similar dilemma under the employer mandates. Private employers have the theoretical option of withdrawing from the market. States do not have the option of abandoning their sovereign functions altogether, and sovereignty cannot be exercised without employees. Congress should not be able to put States to the choice of succumbing to the employer mandates or abandoning their sovereign functions. To the extent *Garcia* permits Congress to do so, it should be overruled.

3. The States vigorously dispute many of the federal government's assertions (at 26–33) as to severability, but the federal government has one thing correct: The States' third question presented concerning severability merits independent consideration and should be granted. On this, there is no dispute. But it makes little sense to decide which, if any, of the ACA's constitutional provisions can survive absent its unconstitutional ones without considering the serious constitutional challenges raised by the States' first two questions. The logical course is to consider all of the States' constitutional objections to the ACA, and then decide which of the Act's remaining provisions can survive.

CONCLUSION

The Court should grant the petition in full.

Respectfully submitted,

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508

BILL COBB
Deputy Attorney General for
Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711

October 24, 2011 *Counsel for Petitioners*

AMICUS
CURIAE
BRIEF

No. 11-400

In The
Supreme Court of the United States

◆

STATE OF FLORIDA, *et al.*,

Petitioners,

vs.

UNITED STATES DEPARTMENT OF
HEALTH & HUMAN SERVICES, *et al.*,

Respondents.

◆

**On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit**

◆

AMICI CURIAE BRIEF OF THE AMERICAN CENTER FOR LAW & JUSTICE, 105 MEMBERS OF THE UNITED STATES CONGRESS, AND THE SUPREME COURT COMMITTEE TO DECLARE OBAMACARE UNCONSTITUTIONAL IN SUPPORT OF PETITIONERS

◆

JAY ALAN SEKULOW
Counsel of Record
STUART J. ROTH
COLBY M. MAY
JAMES M. HENDERSON SR.
EDWARD L. WHITE III
ERIK M. ZIMMERMAN
MILES L. TERRY
AMERICAN CENTER FOR
LAW & JUSTICE
[redacted]
Counsel for Amici Curiae

October 26, 2011

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OR CALL COLLECT (402) 342-2831

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I. IDENTITY AND INTEREST OF THE AMICI CURIAE

Amicus curiae, the American Center for Law & Justice ("ACLJ"), is an organization dedicated to defending constitutional liberties secured by law.[1] ACLJ attorneys have argued before this Court and other federal and state courts in numerous cases involving constitutional issues. *E.g.*, *Pleasant Grove City v. Summum*, 129 S. Ct. 1125 (2009); *McConnell v. FEC*, 540 U.S. 93 (2003); *Lamb's Chapel v. Ctr. Moriches Union Free Sch. Dist.*, 508 U.S. 384 (1993). ACLJ attorneys also have participated as amicus curiae in numerous cases involving constitutional issues before this Court and lower federal courts. *E.g.*, *FEC v. Wisconsin Right to Life, Inc.*, 551 U.S. 449 (2007); *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320 (2006); *Van Orden v. Perry*, 545 U.S. 677 (2005).

The ACLJ has been active in litigation concerning the Patient Protection and Affordable Care Act of 2010 ("ACA" or "Act"), in particular, with regard to the "individual mandate" provision, which requires applicable American citizens to purchase and maintain Federal Government-approved health insurance from a private company for the remainder of their lives or be penalized annually. The ACLJ has filed amici curiae briefs in support of the following challenges to the ACA: *Virginia v. Sebelius*, No. 3:10-CV-188-HEH (E.D. Va.) & Nos. 11-1057, 11-1058 (4th Cir.); *TMLC v. Obama*, No. 10-2388 (6th Cir.); and in the case from which the petition originates, *Florida v. United States Dep't of Health & Human Servs.*, No. 3:10-CV-91-RV-EMT (N.D. Fla.) & Nos. 11-11021-HH, 11-11067-HH (11th Cir.).

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[1] No counsel for a party authored this brief in whole or in part. No person or entity aside from amici curiae, their members, and their counsel made a monetary contribution to the preparation or submission of this brief. Amici curiae have no parent corporation and do not issue stock. Counsel of record for the parties received timely notice of the intent to file this brief, and they have filed notices with this Court consenting to the filing of amicus curiae briefs.

Additionally, the ACLJ represents individual plaintiffs in a challenge to the individual mandate: *Mead v. Holder*, No. 1:10-CV-00950-GK (D.D.C.), *appeal sub. nom. Seven-Sky v. Holder*, No. 11-5047 (D.C. Cir.). Oral argument occurred in *Seven-Sky* in the United States Court of Appeals for the District of Columbia Circuit on September 23, 2011, before the Honorable Brett M. Kavanaugh, Harry T. Edwards, and Laurence H. Silberman. A decision is pending. Accordingly, the ACLJ has an interest that may be affected by the instant case because any decision by this Court would be dispositive authority in *Seven-Sky*.

This brief is also filed on behalf of amici curiae United States Representatives Paul Broun, Robert Aderholt, Todd Akin, Rodney Alexander, Steve Austria, Michele Bachmann, Spencer Bachus, Joe Barton, Rob Bishop, Diane Black, Marsha Blackburn, Larry Bucshon, Michael Burgess, Dan Burton, Francisco "Quico" Canseco, Eric Cantor, Steve Chabot, Howard

Coble, Mike Coffman, Tom Cole, Mike Conaway, Chip Cravaack, Geoff Davis, Scott DesJarlais, Jeff Duncan, Blake Farenthold, Stephen Fincher, Chuck Fleischmann, John Fleming, Bill Flores, Randy Forbes, Virginia Foxx, Trent Franks, Cory Gardner, Scott Garrett, Bob Gibbs, Phil Gingrey, Louie Gohmert, Bob Goodlatte, Tom Graves, Tim Griffin, Michael Grimm, Ralph Hall, Gregg Harper, Andy Harris, Vicky Hartzler, Jeb Hensarling, Wally Herger, Tim Huelskamp, Bill Huizenga, Randy Hultgren, Lynn Jenkins, Bill Johnson, Walter Jones, Jim Jordan, Mike Kelly, Steve King, Adam Kinzinger, John Kline, Doug Lamborn, Jeff Landry, James Lankford, Robert Latta, Billy Long, Cynthia Lummis, Connie Mack, Donald Manzullo, Kenny Marchant, Kevin McCarthy, Michael McCaul, Tom McClintock, Thaddeus McCotter, Cathy McMorris Rodgers, Gary Miller, Jeff Miller, Randy Neugebauer, Alan Nunnelee, Pete Olson, Ron Paul, Steve Pearce, Mike Pence, Joe Pitts, Ted Poe, Mike Pompeo, Bill Posey, Tom Price, Ben Quayle, Reid Ribble, Scott Rigell, Phil Roe, Todd Rokita, Dennis Ross, Ed Royce, Steve Scalise, Jean Schmidt, Adrian Smith, Lamar Smith, Marlin Stutzman, Lee Terry, Tim Walberg, Joe Walsh, Daniel Webster, Lynn Westmoreland, Joe Wilson, and Don Young, who are 105 members of the United States House of Representatives in the One Hundred Twelfth Congress, and the Supreme Court Committee to Declare ObamaCare Unconstitutional, which consists of over 29,000 Americans from across the country who oppose the individual mandate.

Amici curiae are dedicated to the founding principles of a limited Federal Government and to the corollary precept that Article I of the Constitution contains boundaries that Congress may not trespass – no matter how serious the nation's healthcare problems. In particular, amici curiae believe that the Constitution does not empower Congress to require Americans to purchase and maintain Federal Government-approved health insurance from a private company for the rest of their lives or pay an annual penalty. Amici curiae are deeply troubled by the fundamental alteration to the nature of our federalist system of government that would be required in order to recognize a novel Congressional power to mandate that citizens buy a product from a private company. Amici curiae urge this Court to grant plenary review in this case.

II. SUMMARY OF THE ARGUMENT

The petition presents three questions for review. Amici curiae urge this Court to grant review of those questions for the reasons stated in the petition. Of primary concern, amici curiae urge this Court to review the third question presented: "Does the Affordable Care Act's mandate that virtually every individual obtain health insurance exceed Congress's enumerated powers and, if so, to what extent (if any) can the mandate be severed from the remainder of the Act?" Pet. at i. This question should be reviewed for two reasons: First, there is a split among the circuit courts of appeal regarding the constitutionality of the individual mandate. This Court should resolve that split on this matter of national importance. Second, even though the United States Court of Appeals for the Eleventh Circuit correctly held that the individual mandate is unconstitutional, it wrongly severed only the individual mandate from the ACA. The individual mandate, by the Federal Government's own admission, is *the* essential component of the ACA. Should this Court also rule the individual mandate unconstitutional, it should decide to what extent (if any) the individual mandate can be severed from the rest of the ACA.

III. ARGUMENT

Although amici curiae urge this Court to grant plenary review in this case, they are most interested in the review of the third question presented: "Does the Affordable Care Act's mandate that virtually every individual obtain health insurance exceed Congress's enumerated powers and, if so, to what extent (if any) can the mandate be severed from the remainder of the Act?" Pet. at i. This Court should review this third question for the following reasons:

A. THIS COURT SHOULD GRANT REVIEW AND DECIDE WHETHER THE INDIVIDUAL MANDATE EXCEEDS CONGRESS'S ENUMERATED POWERS

This case arises from a challenge to the federal law known as the Patient Protection and Affordable

Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("ACA" or "Act"). Among their various causes of action, Petitioners challenge the constitutionality of the "individual mandate" provision of the ACA, which requires most Americans to purchase and maintain Federal Government-approved health insurance from a private company for the rest of their lives or pay an annual penalty. 26 U.S.C. § 5000A (effective Jan. 1, 2014). The resolution of whether the individual mandate is constitutional is a matter of national importance.

A split now exists in the circuit courts of appeal regarding the constitutionality of the individual mandate. The United States Court of Appeals for the Sixth Circuit wrongly held the individual mandate constitutional in a 2-1 decision. *TMLC v. Obama*, 2011 U.S. App. LEXIS 13265 (6th Cir. June 29, 2011). By contrast, the United States Court of Appeals for the Eleventh Circuit correctly held that the individual mandate is unconstitutional in a 2-1 decision. The Eleventh Circuit properly concluded that the Commerce Clause does not give Congress the power to require American citizens to purchase a product from a private company for the remainder of their lives or be penalized annually, and the court also properly noted that there would be no judicially-administrable limits to Congress's power that would prevent Congress from mandating numerous other purchases from private companies if the Act's individual mandate were upheld.[2] Pet. App. at 167-72 (*Florida v. United States Dep't of Health & Human Servs.*, 648 F.3d 1235, 1311-13 (11th Cir. 2011)).

Owing to the circuit court split on this matter of national importance, amici curiae urge this Court to exercise its discretion and grant the petition to resolve this conflict. A grant of review is appropriate in this case. Sup. Ct. R. 10 (explaining that this Court may properly exercise its discretion by granting a petition for writ of certiorari to resolve a circuit court split); *Milner v. Dep't of the Navy*, 131 S. Ct. 1259, 1264 (2011) (granting writ of certiorari to resolve a circuit court split); *Fox v. Vice*, 131 S. Ct. 2205, 2212-13 (2011) (same).[3]

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[2] The Sixth and Eleventh Circuits both correctly ruled that the individual mandate is not supported by Congress's taxing power. *TMLC*, 2011 U.S. App. LEXIS 13265 at *52-64, *100; Pet. App. at 173-89 (*Florida*, 648 F.3d at 1313-20).

[3] Other challenges to the ACA are pending in the circuit courts of appeal, including *Seven-Sky v. Holder*, No. 11-5047 (D.C. Cir.). On September 23, 2011, the Honorable Brett M. Kavanaugh, Harry T. Edwards, and Laurence H. Silberman heard oral argument on the following issues: whether Congress was authorized to enact the individual mandate through its Commerce or Taxing Clause powers and whether the Anti-Injunction Act applies to the case. Also involved in *Seven-Sky* is whether the individual mandate violates the rights of certain plaintiffs pursuant to the Religious Freedom Restoration Act, 42 U.S.C. §§ 2000bb *et seq*. The parties are awaiting a decision.

B. THIS COURT SHOULD GRANT REVIEW AND DECIDE TO WHAT EXTENT (IF ANY) THE INDIVIDUAL MANDATE CAN BE SEVERED FROM THE REST OF THE ACA

The Eleventh Circuit reversed the district court's well-reasoned determination that the unconstitutional individual mandate cannot be severed from the ACA and, as such, the entire Act is invalid. Pet. App. at 382-97 (*Florida v. United States Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1299-1305 (N.D. Fla. 2011)). The Eleventh Circuit determined instead that *only* the unconstitutional individual mandate may be severed from the ACA. Pet. App. at 189-205 (*Florida*, 648 F.3d at 1320-28). In that regard, the Eleventh Circuit erred.

"The inquiry into whether a statute is severable is essentially an inquiry into legislative intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). "Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently." *Alaska Airlines v. Brock*, 480 U.S. 678, 684 (1987). A court must ask "whether [after removing the invalid provision] the [remaining] statute will function in a manner consistent with the intent of Congress." *Id.* at 685 (original emphasis omitted).

Two factors demonstrate that Congress did not intend the individual mandate to be severable. First, the Affordable Health Care for America Act (H.R. 3962), which the House approved on November 7, 2009, contained an individual mandate section as well as a severability provision.[4] H.R. 3962's severability provision, however, was not included in the final version of the ACA. Congress's *conscious* rejection of a severability clause in the ACA is strong evidence that Congress did not intend for the statute's individual provisions to be severable.

Second, Congress could not have intended the individual mandate to be severable if severing it would allow an inoperable or counterproductive regulatory scheme to stand. *See Alaska Airlines*, 480 U.S. at 684; *accord Free Enter. Fund. v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161-62 (2010). The Federal Government has conceded that the individual mandate is essential to the ACA. As such, without the individual mandate, the Act's remaining portions cannot function "in a manner consistent with the intent of Congress." *See Alaska Airlines*, 480 U.S. at 685. For example, in *Mead v. Holder*, No. 1:10-CV-00950-GK (D.D.C.), which is now on appeal in the District of Columbia Circuit as *Seven-Sky v. Holder*,

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[4] Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 255 (2009), *available at Bill Summary & Status*, http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.3962: (click on "Text of Legislation," then the link for "Affordable Health Care for America Act (Engrossed in House [Passed House]-EH)").

No. 11-5047, the Federal Government asserted in the district court that the individual mandate is essential to the workings of the ACA. The Federal Government stated

- that the ACA's *"reforms of the interstate insurance market . . . could not function effectively without the* [*individual mandate*] *provision."* Memorandum in Support of the Defendants' Motion to Dismiss at 22, Doc. 15-1, ***Mead v. Holder***, No. 1:10-cv-950-GK (D.D.C.) (emphasis added);
- that the *individual mandate is "an 'essential' part of the Act's larger regulatory scheme for the interstate health care market," id.* (emphasis added);
- that *Congress found the individual mandate "not only is adapted to, but is 'essential' to, achieving key reforms of the interstate health care and health insurance markets," id.* at 24 (emphasis added); and
- that *"Congress determined*, also with substantial reason, *that* [*the individual mandate*] *provision was essential to its comprehensive scheme of reform. Congress acted well within its authority to integrate the provision into the interrelated revenue and spending provisions of the Act." Id.* at 31 (emphasis added).

The Federal Government made similar concessions in other district court challenges to the ACA concerning the importance of the individual mandate to the overall Act. In the United States District Court for the Eastern District of Virginia, the Federal Government maintained that the individual mandate "*is essential to the comprehensive regulation Congress enacted.*" Memorandum in Support of Defendants' Motion for Summary Judgment at 26, Doc. 91, *Virginia v. Sebelius*, No. 3:10-cv-188-HEH (E.D. Va.) (emphasis added). And, in the instant case, the Federal Government asserted in the United States District Court for the Northern District of Florida that "*Congress found that* [*the individual mandate*] '*is an essential part of this larger regulation of economic activity,' and that its absence 'would undercut Federal regulation of the health insurance market.*'" Memorandum in Support of Defendants' Motion for Summary Judgment at 11, 20, Doc. 82-1, *Florida v. United States Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV-EMT (N.D. Fla.) (emphasis added) (quoting ACA §§ 1501(a)(2)(H), 10106(a)).

Indeed, as Petitioners point out, the Federal Government, while this case was pending in the Eleventh Circuit, conceded, in particular, that the individual mandate is essential to at least two other provisions of the ACA: the guaranteed issue provision, 42 U.S.C. § 300gg-1 (effective Jan. 1, 2014), and the prohibition on preexisting condition exclusions, 42 U.S.C. § 300gg-3 (effective Jan. 1, 2014). Pet. at 31-32. Although ignored by the Eleventh Circuit, this same concession was recently accepted by the United States District Court for the Middle District of Pennsylvania. The district court ruled on September 13, 2011, that the individual mandate is unconstitutional and must be severed from the ACA along with the guaranteed issue and preexisting conditions provisions. *Goudy-Bachman v. United States Dep't of Health & Human Servs.*, 2011 U.S. Dist. LEXIS 102897 at *64-73 (M.D. Pa. Sept. 13, 2011); *id.* at *68 (explaining that the Federal Government conceded that the guaranteed issue and preexisting conditions provisions are "'absolutely intertwined'" with the individual mandate and "must be severed should the individual mandate provision be severed").

In sum, the Eleventh Circuit erred in severing the individual mandate from the ACA. The Federal Government has conceded that the individual mandate is essential to Congress's reforms of the health insurance and health care markets (and, at minimum, is "absolutely intertwined" with the guaranteed issue provision and the preexisting conditions provision of the ACA). Those concessions, in addition to the lack of a severability provision and the divergent severability rulings of federal courts, underscore the need for this Court to accept review of this case. This Court should resolve these and the other questions presented.

IV. CONCLUSION

Amici curiae respectfully request that this Court grant the petition.

Respectfully submitted,

JAY ALAN SEKULOW
Counsel of Record
STUART J. ROTH
COLBY M. MAY
JAMES M. HENDERSON SR.
EDWARD L. WHITE III
ERIK M. ZIMMERMAN
MILES L. TERRY
AMERICAN CENTER FOR
LAW & JUSTICE
[redacted]

October 26, 2011

Counsel for Amici Curiae

AMICUS CURIAE BRIEF

Nos. 11-393, 11-398, 11-400

In the
Supreme Court of the United States

NAT. FED'N OF INDEP. BUSINESS v.
SEBELIUS, SEC. OF HHS, ET AL.

DEPT. OF HHS, ET AL. v.
FLORIDA, ET AL.

FLORIDA, ET AL. v.
DEPT. OF HHS ET AL.

**On Writ of Certiorari to the
United States Court of Appeals
For the Fifth Circuit**

AMERICAN CIVIL RIGHTS UNION *AMICUS CURIAE* BRIEF IN SUPPORT OF PETITIONERS ON SEVERABILITY

Peter Ferrara
Counsel of Record
American Civil Rights Union
310 Cattell Street
Easton, PA 18042
610-438-5721

*Counsel for Amicus Curiae
American Civil Rights Union*

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INTEREST OF THE *AMICUS CURIAE*[1]

The American Civil Rights Union is a non-partisan, non-profit, 501(c)(3), legal/educational policy organization dedicated to defending all of our constitutional rights, not just those that might be politically correct or fit a particular ideology. It was founded in 1998 by long time policy advisor to President Reagan, and the architect of modern welfare reform, Robert B. Carleson. Carleson served as President Reagan's chief domestic policy advisor on federalism, and originated the concept of ending the federal entitlement to welfare by giving the responsibility for those programs to the states through finite block grants. Since its founding, the ACRU has filed *amicus curiae* briefs on constitutional law issues in cases nationwide.

Those setting the organization's policy as members of the Policy Board are former U.S. Attorney General, Edwin Meese III; former Assistant Attorney General for Civil Rights, William Bradford Reynolds; former Assistant Attorney General for the Office of Legal Counsel, Charles J. Cooper; John M. Olin Distinguished Professor of Economics at George Mason University, Walter E. Williams; former Harvard University Professor, Dr. James Q. Wilson;

---

[1] Peter Ferrara authored this brief for the American Civil Rights Union (ACRU). No counsel for either party authored the brief in whole or in part and no one apart from the ACRU made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this brief, and were timely notified.

former Ambassador Curtin Winsor, Jr.; former Assistant Attorney General for Justice Programs, Richard Bender Abell and former Ohio Secretary of State J. Kenneth Blackwell.

This case is of interest to the ACRU because we seek to ensure that the Constitutional limits to federal power are fully recognized and enforced. That includes in regard to this case in particular that the scope and boundaries of the Commerce Clause be fully respected and maintained, and properly applied to analysis of the constitutionality of the Patient Protection and Affordable Care Act.

SUMMARY OF ARGUMENT

Because the ACA does not include a severability clause, if the individual mandate is found unconstitutional, then the whole Act must be struck down as unconstitutional.

The government itself has repeatedly argued in this case and in other cases across the country that the ACA cannot function without the individual mandate, because of the Act's regulatory requirements for guaranteed issue and community rating. Because of those regulatory requirements, without an individual mandate requiring everyone to purchase health insurance, the result would be a financial death spiral for the health insurance industry that is supposed to provide coverage for everyone under the Act.

If regulation required fire insurers to issue policies to people whose houses were already on fire at standard rates, the fire insurance pool would include only all burned down houses, which would obviously be dysfunctional.

The resulting financial death spiral would cause the costs of other provisions of the ACA to soar, such as the subsidies for purchase of health insurance on the Exchanges, which would be even more costly than expected, and the costs for the Medicaid expansion, where more people would qualify given the decline of private insurance.

For these foregoing reasons, this Court should reverse the ruling of the court below on the severability issue.

ARGUMENT

I. THE INDIVIDUAL MANDATE CANNOT BE SEVERED, THEREFORE THE WHOLE ACA MUST BE FOUND UNCONSTITUTIONAL.

The ACA does not include a severance clause. Consequently, if the individual mandate is found unconstitutional, the question becomes whether the remaining parts of the ACA can still remain fully operative as law and function as Congress intended, and whether Congress would have passed the ACA without the individual mandate. *Alaska Airlines v. Brock*, 480 U.S. 678 (1987); *Free Enterprise Fund v. Public Co. Accounting Oversight Board*, 130 S. Ct.

3138 (2010); *Williams v. Standard Oil Co.*, 278 U.S. 235 (1929); *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 636 (1895); *see also R.R. Ret. Bd. v. Alton R.R. Co.*, 295 U.S. 330, 362 (1935) (invalid parts "so affect[ed] the dominant aim of the whole statute as to carry it down with them").

The answer in both cases is indisputably no. HHS itself has repeatedly argued in this case and in other cases across the country that the ACA cannot function without the individual mandate. That is because of the Act's regulatory requirements for guaranteed issue and community rating. The Act requires all insurers to cover all pre-existing conditions and issue health insurance to everyone that applies, no matter how sick they are when they first apply or how costly they may be to cover. *ACA, Sections 2702, 2704, 2705.* This is what is known as guaranteed issue.

The Act also prohibits insurers from varying their rates based on the medical condition or illnesses of applicants. Insurers can only vary rates within a limited range for age, geographic location, and family size. *ACA, Section 2701.* This regulatory requirement is known as modified community rating.

Under these regulatory requirements, younger and healthier people delay buying insurance, knowing they are guaranteed coverage at standard rates after they become sick. Sick people show up applying for an insurer's health coverage for the first time with very costly illnesses such as cancer and heart disease, which the insurer must then cover and pay for, out of the same standard premiums as everyone else pays. This means the insurer's covered risk pool includes more costly sick people and fewer less costly healthy people, so the costs per person covered soar. The insurer then has to raise rates sharply for everyone just to be sure to have enough money to pay all of the policy's benefits.

Those higher rates encourage even more healthy people to drop their insurance, leaving the remaining pool even sicker and more costly on average, which requires even higher premiums, resulting in a financial death spiral for the insurers and the insurance market.

If regulation required fire insurers to issue policies to people whose houses were already on fire at standard rates, the fire insurance pool would include only all burned down houses, which would obviously be dysfunctional.

The ACA tries to counter this problem by adopting the individual and employer mandates, seeking to require everyone to be covered and contributing to the pool at all times. Without these mandates, the government itself has repeatedly argued, those who would remain uninsured would substantially affect the interstate market for health insurance, by allowing the remaining regulatory requirements to cause soaring health insurance premiums through the above process and ultimately a financial death spiral.

That financial death spiral would cause the costs of other provisions of the ACA to soar, such as the subsidies for purchase of health insurance on the

Exchanges, which would be even more costly than expected, and the costs for the Medicaid expansion, where more people would qualify given the decline of private insurance.

Indeed, the ACA itself in its very statutory language recognized the essential role of the individual mandate in the statute's overall framework, saying in Section 1501(a)(2)(I),

> "[I]f there were no [individual mandate], many individuals would wait to purchase health insurance until they needed care....The [individual mandate] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold."

As the court in *Alaska Airlines* said, "Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently...." 480 U.S. at 684.

Moreover, as *Alaska Airlines* also recognized, in the absence of a statutory severance clause the entire statute must be struck down if Congress would not have enacted the statute without the unconstitutional provision. 480 U.S. at 678. The narrow margin of passage of the ACA greatly increases the probability that Congress would not have passed the ACA without the individual mandate. The loss of that provision so centrally affects the entire structure of the Act that without it the entire structure must fall. Trying to determine what could be salvaged would embroil the Court in rewriting the statutory policy and framework to govern one-sixth of the entire U.S. economy.

The District Court below recognized the validity of exactly these arguments in striking down the entire PPACA. The court said,

> "[O]n the unique facts of this particular case, the record seems to strongly indicate that Congress would not have passed the Act in its present form if it had not included the individual mandate. This is because the individual mandate was indisputably essential to what Congress was ultimately seeking to accomplish. It was, in fact, the keystone or lynchpin of the entire health reform effort."

(Slip Op. at 67). Indeed, the court's analysis of the legislative history of the ACA concluded that the absence of a severability clause in the Act was intentional, reflecting Congress's judgment that the ACA was not functional without the individual mandate. (Slip Op. at 67-68). The court added,

> "Severing the individual mandate from the Act along with the other insurance reform provisions – and in the process reconfiguring an exceedingly lengthy and comprehensive legislative scheme – cannot be done consistent with the principles set out above. Going through the 2,700-page Act line-by-line, invalidating dozens (or hundreds) of some sections while retaining dozens (or hundreds)

> of others, would not only take considerable time and extensive briefing, but it would, in the end, be tantamount to rewriting a statute in an attempt to salvage it, which is foreclosed by *Ayotte, supra*. Courts should not even attempt to do that....The interoperative effects of a partial deletion of legislative provisions are often unforeseen and unpredictable. For me to try and 'second guess' what Congress would want to keep is almost impossible."

(Slip Op. at 72-73). The court consequently rightly concluded,

> "In the final analysis, this Act has been analogized to a finely crafted watch, and that seems to fit. It has approximately 450 separate pieces, but one essential piece (the individual mandate) is defective and must be removed. It cannot function as originally designed. There are simply too many moving parts in the Act and too many provisions dependent (directly and indirectly) on the individual mandate and other health insurance provisions—which, as noted, were the chief engines that drove the entire legislative effort—for me to try and dissect out the proper from the improper, and the able-to-stand-alone from the unable-to-stand-alone. Such a quasi-legislative undertaking would be particularly inappropriate in light of the fact that any statute that might conceivably be left over after this analysis is complete would plainly not serve Congress' main purpose and primary objective in passing the Act....The

> Act, like a defectively designed watch, needs to be redesigned and reconstructed by the watchmaker."

(Slip Op. at 73-74).

CONCLUSION

For all of the foregoing reasons, *amicus curiae* American Civil Rights Union respectfully submits that this Court should reverse the ruling of the court below on the severability issue.

Peter Ferrara
American Civil Rights Union
310 Cattell Street
Easton, PA 18042
610-438-5721
703-582-8466

Counsel for *Amicus Curiae*
American Civil Rights Union

AMICUS
CURIAE
BRIEF

Nos. 11-393, 11-398, and 11-400

In The
Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, *ET AL.*,
Petitioners,
v.
KATHLEEN SEBELIUS, SECRETARY OF HEALTH & HUMAN SERVICES, *ET AL.*

DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*,
Petitioners,
v.
FLORIDA, *ET AL.*

FLORIDA, *ET AL.*,
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DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*

On Petitions for Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN PARTIAL SUPPORT OF CERTIORARI REVIEW

JOSEPH MILLER
JULIE SIMON MILLER
AMERICA'S HEALTH INSURANCE PLANS
601 Pennsylvania Avenue, N.W.
South Building, Suite 500
Washington, DC 20004
(202) 778-3200

PATRICIA A. MILLETT
Counsel of Record
KEVIN R. AMER
AKIN, GUMP, STRAUSS, HAUER & FELD LLP
1333 New Hampshire Ave., N.W
Washington, DC 20036
(202) 887-4000
pmillett@akingump.com

QUESTIONS PRESENTED

Amicus curiae, America's Health Insurance Plans, submits this brief in support of this Court's review of the following questions:

I. Whether Congress had the legislative power under Article I of the Constitution to enact the minimum individual insurance coverage mandate, 26 U.S.C. § 5000A, of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. [This is Question I in No. 11-398 and is Question III in No. 11-400.]

II. Whether, if the minimum individual insurance coverage mandate exceeds congressional power, the mandate is severable in whole or in part from the balance of the Act. [This is the only Question Presented in No. 11-393 and is Question III in No. 11-400.]

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In The
Supreme Court of the United States

No. 11-393

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, *ET AL.*,

Petitioners,

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH & HUMAN SERVICES, *ET AL.*

No. 11-398

DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*,

Petitioners,

v.

FLORIDA, *ET AL.*

No. 11-400

FLORIDA, *ET AL.*,

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DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*

On Petitions for Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN PARTIAL SUPPORT OF CERTIORARI REVIEW

INTEREST OF THE *AMICUS CURIAE*[1]

America's Health Insurance Plans ("AHIP") is a national trade association representing companies that provide health insurance coverage to more than 200 million Americans. Its members offer a wide range of insurance options to consumers, employers of all sizes, and governmental purchasers nationwide, providing AHIP with a unique understanding of how the Nation's health care and health insurance processes work.

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[1] All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk of this Court. No counsel for a party authored this brief in whole or in part, and no person other than amicus made a monetary contribution intended to fund the preparation or submission of this brief.

Health insurance plans are among the entities most directly and extensively regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA" or "Act"). AHIP therefore has a unique perspective on both the practical impact of the Act and the measures necessary to achieve compliance with its requirements. In addition, given its members' extensive experience working with affected parties throughout every sector of the health care system, AHIP is uniquely positioned to address the highly complex and interdependent nature of ACA's various provisions, including the relationship between the individual mandate and ACA's market reforms.

AHIP has previously appeared as *amicus curiae* before this Court in other cases involving issues of particular importance to the health insurance industry. *See, e.g., Health Care Service Corp. v. Pollitt, cert. granted*, 130 S. Ct. 396 (2009) (No. 09-38) (removability to federal court of suits under the Federal Employees Health Benefits Act), *cert. dismissed*, 130 S. Ct. 1574 (2010); *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (judicial review of benefit determinations by ERISA plan administrators); *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (ERISA preemption of state-law claims against health maintenance organizations) (brief filed as AAHP-HIAA).

SUMMARY OF THE ARGUMENT

The parties' certiorari briefs extensively address the legal questions surrounding the constitutionality of ACA's individual mandate provision. AHIP therefore submits this brief to focus on two issues of utmost concern to AHIP and its members: (i) the urgency of this Court's consideration and resolution of that constitutional question this Term, and (ii) the vital importance of the Court obtaining full briefing on the severability question to ensure that, should the mandate be struck down, this Court can also comprehensively consider and resolve this Term the question of the mandate's severability from the balance of the Act and the scope of statutory invalidation.

At the root of this litigation are the individual mandate and its relationship to ACA's remaining provisions. Taken together, those provisions will fundamentally shift the way that health insurance is configured, financed, marketed, and sold, eliminating many of the risk management measures upon which insurers have relied for decades. The magnitude of those changes means that health plans must make and implement numerous critical decisions now to ensure their ability to comply as requirements come into effect in the coming years. Those comprehensive compliance efforts, however, are being conducted in a cloud of uncertainty about the durability of the monumental changes being made and the legal regime that will govern insurance plans going forward. Only a prompt and definitive ruling by this Court on the individual mandate's constitutionality can restore needed certainty to the health care market.

The widely divergent conclusions reached by the lower courts that have addressed the individual mandate's severability from the balance of the Act have compounded the uncertainty under which health plans are laboring. The health insurance industry cannot meaningfully predict whether, if the mandate were to be struck down, its business operations should be reformulated to comply with an Act in which the mandate would be severed completely from the Act (as the Eleventh Circuit held), or partially severed (as two district courts have held), or is inseverable and the entire statute falls (as one district court has held).

Definitive resolution of these issues is a matter of vital importance to the health care industry. Since ACA's enactment, health plans have made extensive efforts to bring their businesses, products, and services into compliance with the Act's provisions as they have come into effect. But now, given the conflicting court decisions, they are confronted with four potential and very different regulatory scenarios under which they must be prepared to meet vital health insurance needs in short order: (i) under ACA; (ii) without ACA; (iii) in a world where there is no individual mandate, but the rest of ACA remains intact; and (iv) in a world in which the individual mandate is stricken from ACA along with some other, as-yet unknown subset of provisions. Each of those scenarios would present a vastly different set of obligations for health care plans. Thus, if the Court were to rule that the individual mandate is unconstitutional, the Court's fully considered analysis of the severability question this Term will be necessary to resolve the interconnectedness and workability of the remaining provisions.

As important as definitive resolution of the severability question is to the insurance industry, the question is also complex. Severability analysis must take into account the background against which Congress legislated, which included substantial experiential evidence that decoupling the individual mandate from market reforms could destabilize the individual insurance market. As Congress was aware, each of the eight States that had enacted market reforms without a mandate experienced severe market disruptions in the form of higher premiums, lower enrollment, and a general failure to achieve the goals articulated by the state legislatures. To ensure that it has the benefit of the parties' full analysis of whether Congress would have enacted the market reforms and other provisions of ACA in the absence of an individual mandate, AHIP agrees with the United States that the Court should direct the parties to include focused briefing on the question of severability.

Accordingly, AHIP respectfully requests that the Court grant review of the single question presented in No. 11-393, the first question presented in No. 11-398, and the third question presented in No. 11-400.

ARGUMENT

I. A DEFINITIVE RULING BY THIS COURT IS URGENTLY NEEDED BECAUSE HEALTH PLANS ARE REQUIRED TO TAKE COMPLIANCE MEASURES AMID DEEP UNCERTAINTY ABOUT THE CONSTITUTIONALITY OF THE INDIVIDUAL MANDATE

ACA legislated a sweeping transformation of the health care market, requiring fundamental changes in the way health insurance is configured, financed, marketed, and sold. The continuing uncertainty over which, if any, of the statute's requirements will ultimately be implemented is heavily straining the good-faith efforts of the member companies to prepare for compliance with ACA and its comprehensive overhaul of the insurance industry. As more and more resources and planning have been poured into rapidly cascading obligations, the legal landscape has grown increasingly unstable and unpredictable. A definitive resolution of the individual mandate's constitutionality thus is crucial to the ability of health plans to timely bring their operations and insurance products into compliance.

Beyond that, the health care market represents over 17% of the national economy. Stability in the governing legal regime and certainty as to whether ACA remains effective in whole or in part going forward thus is critical to the Nation's economic health and is urgently needed by not just the member companies, but also their individual customers, business clients, and state government regulators.

ACA provides for its manifold requirements to be implemented in accelerated stages. The initial provisions became effective within the first six months of enactment and include, *inter alia*, a requirement that health plans provide coverage for dependent adult children until age 26, 42 U.S.C. § 300gg–14(a), and a prohibition on the imposition of lifetime dollar limits for essential health benefits, *id.* § 300gg–11(a)(1)(A).

Additional provisions took effect in 2011, including a requirement that health plans provide rebates to consumers when the plans' medical loss ratios fall below specified thresholds, 42 U.S.C. § 300gg–18(b), and the establishment of a federal and state review process for unreasonable premium increases, *id.* § 300gg–94(a)(1). Compliance with these requirements has necessitated substantial changes in health plans' existing business operations and involves significant ongoing costs.

While bringing themselves into compliance with those provisions already in effect, member companies also have had to prepare for the seismic changes that will occur with the ACA provisions that go into effect on January 1, 2014 and beyond. Among the most significant of those requirements are market reforms that will transform the way that insurance contracts are written, priced and sold, especially in the individual and small group markets. Those changes include "guaranteed issue" and "guaranteed renewability" provisions requiring insurers to issue and renew health care coverage for any individual who applies, 42 U.S.C. §§ 300gg–1, 300gg–2; a "community rating" system that prohibits health plans from adjusting premium prices based on an applicant's health status, and that sharply limits the degree to which premium rates can be varied on the basis of age and tobacco use, *id.* § 300gg(a)(1)(A); and a prohibition on exclusions from coverage on the basis of an applicant's preexisting conditions, *id.* § 300gg–3.

Collectively, those requirements will fundamentally change the existing health insurance market. They will also bring about a dramatic shift in the way health insurers account for and spread risk in the individual insurance market. Under the current system, insurers assess and control costs through the use of underwriting mechanisms that take into account the risk factors and projected treatment needs of individual applicants. Those practices enable health plans to offer lower-priced premiums to younger and healthier individuals, which attract such individuals into the health insurance market and, in turn, create a broader coverage pool across which risk can be spread. *See* Part II.B.1, *infra*. By prohibiting those practices as of January 1, 2014, ACA is requiring health plans to undertake a wholesale and fundamental overhaul of their methods for offering insurance. The sheer magnitude of those changes is requiring an enormous degree of advance planning and resource commitment by health plans to ensure compliance by the statutory effective date.

What is more, the changes that member companies must make to their business operations are fundamental and far-reaching, making it virtually impossible for them to try to unscramble the egg after the fact should a final resolution of the constitutional question not be issued until 2013 or beyond. A scenario in which health plans must restructure every level of their business practices to achieve compliance and then, on the eve of implementation, throw the entire process into reverse, would impose crushing burdens on the insurance industry that would affect every level of the health care system nationwide.

Other health care stakeholders face similar challenges. Employers, for example, will be required by January 1, 2014 to meet a broad range of substantive and administrative obligations, including offering minimum essential coverage to all full-time employees and their dependents, 26 U.S.C. § 4980H(a); automatically enrolling full-time employees in coverage, 29 U.S.C. § 218a; and providing detailed reports to the Department of Health and Human Services, 26 U.S.C. § 6056.

Within that same timeframe, the States must undertake the massive administrative task of establishing Health Insurance Exchanges to facilitate the purchase of insurance in both the individual and small group markets. 42 U.S.C. § 18031. With the implementation date just over two years away, these stakeholders must make critical budgetary, investment, and employment decisions now and in the near future to have any realistic hope of achieving compliance.

Unfortunately, those decisions are being made within an environment of significant uncertainty. Additionally, given the possibility that this Court might hold the individual mandate unconstitutional and inseverable, in whole or in part, the uncertainty extends to the future application and workability of the remaining interrelated provisions of ACA.

For the member companies, the effect of this ongoing uncertainty is particularly manifest in the action (or inaction) of their state governmental regulators. As of September 2011, fewer than half the States had taken steps to create a Health Insurance Exchange, *see* Henry J. Kaiser Family Foundation, Health Reform Source, http://healthreform.kff.org/the-states.aspx. For at least some States, that inaction is partly attributable to uncertainty over the outcome of this litigation and other challenges to the ACA. *See, e.g.*, Grant Schulte, *Heineman: Nebraska will wait for health care ruling*, Associated Press, Oct. 3, 2011 ("Nebraska will not enact a health care exchange mandated by the federal health care overhaul until officials know for sure whether the measure is constitutional."); N.M. Senate Executive Message No. 53 (Apr. 8, 2011) (vetoing bill to implement exchange structure on ground that legislation was "premature" and noting that "challenges to specific components of the federal law have been brought in several federal and district courts and are ongoing").

All of this paralyzing uncertainty—among health plans, employers, government regulators, and others—underscores the vital need for a prompt and conclusive resolution of the constitutional challenge to the individual mandate. AHIP therefore respectfully urges the Court to grant review of that issue and to resolve it this Term.

II. THE COURT SHOULD OBTAIN BRIEFING ON AND, IF NECESSARY, CONCLUSIVELY RESOLVE THE QUESTION OF SEVERABILITY

ACA is a 2,700-page statute consisting of hundreds of interrelated requirements, making the question of severability one of enormous importance to the insurance industry. Any decision invalidating the individual mandate could have profound implications for the workability of many other requirements and for the member companies' practical ability to implement the law's obligations. In particular, the historic experience under State laws documents that the economic viability and sustainability of the market reforms—*e.g.*, the guaranteed issue, community rating requirements, and preexisting condition provisions—can be materially affected by the existence (or not) of an individual mandate. Having witnessed what occurred in States that had enacted market reforms without an individual mandate, Congress legislated against a backdrop of powerful proof that decoupling the mandate from those other requirements would destabilize the insurance market throughout the Nation.

Accordingly, AHIP joins the United States' request (Consol. Response Br. 10-11) that, if the Court grants review on the underlying constitutional question, the Court also order supplemental briefing devoted to analysis of the severability question. That will ensure that, if the Court were to invalidate the mandate, the Court could in this same case conclusively and timely resolve the impact of that invalidation on the balance of ACA's provisions, rather than leave companies in a profound state of confusion and instability during the critically important months and years ahead.

A. The Severability Question Has Produced Sharply Different Court Rulings

Four courts have analyzed the severability question and have reached four different answers. Each of those courts determined that the severability analysis is governed by this Court's decision in *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987), but they divided sharply on the proper application of that test in ACA's unique context. *See generally* States' Petition for Certiorari at 29-33 (No. 11-400) (discussing the conflicting rulings).

The district court in *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010), found it "virtually impossible within the present record to determine whether Congress would have passed this bill" in the absence of the mandate, *id.* at 789, and accordingly severed only those provisions that "make specific reference to" the mandate, *id.* at 790.

Reaching a somewhat different conclusion, the court in *Goudy-Bachman v. United States Department of Health & Human Services*, No. 1:10-CV-763, — F. Supp. 2d —, 2011 WL 4072875 (M.D. Pa. Sept. 13, 2011), recently ruled that the guaranteed issue and preexisting condition provisions could not be severed from the individual mandate, but that all other provisions could remain in place, *id.* at *21.

In contrast, the district court in this case held that the individual mandate is "inextricably bound together in purpose" with the remaining provisions, and that the invalidation of the mandate therefore required striking down ACA in its entirety. U.S. Pet. App. 363a.

The Eleventh Circuit, however, reversed that holding, concluding that the strong "presumption of severability" dictated that all provisions of ACA other than the mandate should remain intact. U.S. Pet. App. 184a. Despite the United States' concession that the guaranteed issue and community rating provisions (including the ban on preexisting condition exclusions) would have to be severed with the mandate, the court of appeals determined that those provisions and the balance of the statute could be "'fully operative as a law,'" and on that basis ruled that the mandate was fully severable. U.S. Pet. App. 174a. The court, however, did not address the further question, required by *Alaska Airlines*, of whether a mandate-free ACA would "function in a manner consistent with * * * the original legislative bargain," 480 U.S. at 685 (emphasis omitted), or whether Congress would "have been willing * * * to enact" the law without the mandate, *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 636 (1895) (citation omitted).

In addition, the Eleventh Circuit relied on what it viewed as a "paucity" of modern precedents in which this Court determined that a constitutionally invalid provision of a law could not be severed from *any* portion of the law. U.S. Pet. App. 173a. That empirical observation, however, is not only mistaken, but also irrelevant because it says nothing about the proper outcome of this Court's severability analysis in any given case and, in particular, as applied to a statute as complex, interconnected, and painstakingly legislated as ACA.[2]

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[2] The Eleventh Circuit's observation overlooked two relatively recent decisions in which this Court held that a constitutionally invalid provision of a law could not be completely severed. In *Randall v. Sorrell*, 548 U.S. 230 (2006), this Court held that an unconstitutional Vermont campaign finance statute was not severable from other constitutionally valid contribution limits because severance would have required the Court "to write words into the statute," *id.* at 262. And in *United States v. Booker*, 543 U.S. 220 (2005), the Court held that the unconstitutional scheme of enhanced sentences under the federal Sentencing Guidelines could not be severed from the provisions of the statute that made the Guidelines mandatory and that called for *de novo* appellate review of departures by

That widespread divergence in the outcome of the courts' severability analyses, by itself, underscores the complexity of the severability question under ACA and thus the particularized need for this Court to order briefing devoted to the question.[3] The necessity of such cautious deliberation and focused briefing is amplified still further by the position of the United States (Consol. Response Br. 31) that the mandate is not entirely severable from ACA's market reforms (*i.e.*, the guaranteed issue and community rating provisions), and Congress's own finding that the mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold," 42 U.S.C. § 18091(a)(2)(I).

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district courts, because both of those provisions necessarily depended on the existence of the Guidelines enhancement scheme, *id.* at 259-260.

[3] To be sure, this Court does not commonly consider conflicting district court decisions in its certiorari calculus. But in this case, the severability issue is automatically embedded in the constitutional question on which the circuits are in plain conflict. The conflicting lower courts decisions thus are relevant to the subsidiary question of whether the complexity of the severability analysis in this case merits focalized briefing.

B. Severability Analysis Must Be Undertaken Against the Backdrop, Well Known to Congress, of Prior, Failed Legislative Efforts to Enforce Market Reforms Without an Individual Mandate

1. ACA's Market Reforms Require an Individual Mandate to Prevent Economically Unviable Adverse Selection and Cost-Shifting

To determine whether a law can "function in a manner consistent with * * * the original legislative bargain," *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted), courts must consider the experiential backdrop against which Congress legislated. Here, that history of failed legislative efforts to implement market reforms without an adequate individual mandate should substantially inform the question whether Congress intended the guaranteed issue, preexisting condition, and community ratings provisions, along with the Act's other health insurance market reforms, to continue to operate if the individual mandate were invalidated.

By way of background, health insurance is generally sold in three markets: non-group (also known as the individual market), small group, and large group. Approximately 14 million Americans purchase health insurance on the individual market. Henry J. Kaiser Family Foundation, *The Uninsured, A Primer: Key Facts About Americans Without Health Insurance*, 31 (Dec. 2010).

Under the current system, the individual market is particularly susceptible to the economic phenomenon of "adverse selection" and the closely-related problem of cost-shifting. *See* Kathryn Linehan, *Underwriting in the Non-Group Health Insurance Market: The Fundamentals* 4 (June 4, 2009). Adverse selection occurs because individuals with higher anticipated health care costs—generally less healthy or older individuals—are more likely than healthy, younger people to enter an insurance market. Members of the latter group, for whom the risk of significant health care needs and expenses is more remote, are more likely as a consequence to wait to purchase coverage until they suffer from an illness or expect to need medical treatment.

Such adverse selection increases costs for all participants in the insurance pool. Because insurers generally set premiums according to the expected medical costs of those participating in a coverage pool, premiums increase for all participants when individuals with higher expected health care costs constitute a majority of the pool. Linda Blumberg & John Holahan, *Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues* 2 (Jan. 2008). The result is that healthy people become even less inclined to purchase coverage. Indeed, up to 20% of uninsured individuals have the financial means to obtain coverage but forgo it, relying instead on emergency care when they need medical treatment. Lucien Wulsin, Jr. & Adam Dougherty, *Individual Mandate: A Background Report* 3-4 (Apr. 2009). Those costs, in turn, are shifted to the insured in the form of higher premiums. Such cost-shifting creates a "hidden tax" ranging from two to ten percent of private premiums. *Id.* at 4.

To combat those problems of adverse selection and cost-shifting, many States allow for premium rates in the individual market to be set through the actuarial mechanism of underwriting. That process allows insurers to manage costs by assessing each applicant's health and making an actuarial judgment about the amount and types of medical services he or she is likely to need. Based on that determination, the insurer might exclude coverage for an applicant's known preexisting conditions, impose a waiting period, adjust the applicant's premium, or deny coverage altogether. *See* Linehan, *supra*, at 4-6. Those underwriting practices allow insurers to offer lower premiums to younger, healthier people, thereby reducing the incentives for such individuals to postpone obtaining coverage until they need medical treatment. *Ibid.*

ACA's market reform provisions eliminate many of those risk management tools. For example, the guaranteed issue and guaranteed renewability provisions require insurers to issue and renew health care coverage for all applicants and enrollees who are able to pay the premium. 42 U.S.C. §§ 300gg–1, 300gg–2. The community rating system prohibits insurers from pricing policies according to an applicant's health status. *Id.* § 300gg. And insurers will no longer be permitted to make exclusions on the basis of preexisting conditions, *id.* § 300gg–3; to base coverage eligibility on an applicant's health status, medical condition, or related factors, *id.* §§ 300gg–1, 300gg–4; or to establish a waiting period of more than 90 days, *id.* § 300gg–7.

The effect of those reforms is to alter fundamentally the insurance business and, in particular, the mechanisms employed for spreading risk and controlling premium prices. Without more, prohibiting reliance on the traditional tools of underwriting would make participation in the individual insurance market more attractive for individuals with higher expected health care costs, thereby increasing the pressure on premiums, which in turn renders the insurance market less attractive for those with lower expected costs. That deep imbalance in the pool of insurance customers can create a "marketwide adverse-selection death spiral" in the individual insurance market.[4]

Congress enacted the individual mandate as a counterweight to those economically crippling adverse-selection and cost-shifting problems. The mandate ensures that the individual market includes larger, more representative participant pools across which insurers can viably spread risk. Were the market reforms to be implemented in the absence of the mandate, healthy individuals would have every incentive to take a "wait-and-see" approach to participation in the insurance market. Indeed, since health plans could neither exclude applicants based on preexisting conditions nor increase premiums based on health status, it would be an entirely rational economic decision for healthy and low-medical-risk individuals to forgo obtaining insurance coverage until their medical circumstances changed. At the same time, the most unhealthy or medically risky individuals would have every incentive to flood into the market. As a result, the risk pool would skew toward individuals with higher health care costs. *See* Uwe E. Reinhardt, *The Case for Mandating Health Insurance*, N.Y. Times, Oct. 23, 2009.

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[4] Alan C. Monheit, *et al.*, *Community Rating and Sustainable Individual Health Insurance Markets in N.J.*, 23 Health Affairs 167, 169 (2004).

Congress, moreover, was fully aware of the adverse implications of adopting market reforms unaccompanied by an individual mandate. The Congressional Budget Office advised that, if the market reforms were to be implemented in the absence of the individual mandate, increased adverse selection in the individual market would increase premiums for new policies by approximately 15 to 20 percent. *See* Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010). Similarly, while ACA is projected to expand coverage to 32 million previously uninsured individuals, estimates are that only 8 million of the currently uninsured would obtain coverage if the statute contained no mandate. *See* Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the ACA*, New Eng. J. Med. (Mar. 10, 2011). Empirical evidence thus strongly indicates that a system of market reforms unaccompanied by an individual mandate would create widespread and potentially economically disabling instability in the insurance market and, over time, would substantially reduce access to affordable coverage.

2. *Congress Was Aware That States' Efforts to Implement Similar Market Reforms Without an Individual Mandate Had Largely Failed*

Congress was not writing on a clean slate with ACA. Instead, Congress knew that, when individual

States had attempted to undertake similar insurance market reforms unaccompanied by an individual mandate, the result was substantial economic destabilization and spiraling health care costs. That background must be factored into any severability determination.

In the 1990s, eight States enacted market reforms, including guaranteed issue and community ratings requirements, without an individual mandate. The result in each State was a general destabilization of individual markets, increases in premiums, and declines in enrollment.

For example, Maine enacted guaranteed issue and modified community rating reforms for its individual market in 1993, allowing limited price variation only for age, occupation or industry, and geographic location. *See* B. Gorman, *et al.*, *Reform Options for Maine's Individual Health Insurance Market: An Analysis Prepared for the Bureau of Insurance* 5 (May 30, 2007). According to the Maine Bureau of Insurance's report analyzing the ensuing problems in the individual insurance market, the "market for individual HMO coverage" as of January 2001 "appear[ed] to be in a death spiral." Maine Bureau of Insurance, *White Paper*: *Maine's Individual Health Insurance Market* 4 (Jan. 22, 2001). Premiums for indemnity coverage increased dramatically, and coverage rates plummeted as a result. *Ibid.* State regulators attributed those trends in part to the modified community rating requirement, which "result[ed] in the risk pool having a higher average age and therefore higher costs." *Id.* at 10.

New Jersey's reform efforts tell a similar story. In 1993, New Jersey implemented the Individual Health Coverage Program, which required guaranteed issue, guaranteed renewal, and pure community rating of individual health policies. *See* Alan C. Monheit, *et al.*, *Community Rating and Sustainable Individual Health Insurance Markets in N.J.*, 23 Health Affairs 167, 167 (2004). One study examining the impact of New Jersey's reforms found that, as of 2004, the individual market was "heading for collapse." *Id.* at 168. More than half of the enrollees had left the individual market between 1995 and 2001, and premiums had increased two or three times above their early levels. *Ibid.*

Faced with similar market disruptions after it enacted reforms, Washington succeeded in reversing some of the adverse trends by returning to a more carrier-friendly system. In 1993, Washington enacted comprehensive insurance market reforms, including a guaranteed issue provision, a phased-in community rating requirement, and limits on pre-existing condition exclusions. *See* Adele M. Kirk, *Riding the Bull: Experience With Individual Market Reform in Washington, Kentucky, and Massachusetts,* 25 J. Health Politics, Policy & Law 133, 136-137 (2000). In the ensuing three years, premiums in the individual market rose by as much as 78 percent. *See* Peter Suderman, *The Lesson of State Health-Care Reforms*, Wall St. J., Oct. 15, 2009. Over the same period, enrollment in Washington's individual market fell by 25 percent. *Ibid.*

As a result, the Washington legislature repealed the market reforms, and subsequently enacted legislation to encourage carriers to reenter

Washington's individual market. *See* Robert Wood Johnson Foundation, *Issue Brief: Recognizing Destabilization in the Individual Health Insurance Market* 4 (July 2010). Today, there are five insurance companies participating in the individual market, compared to the two that remained before the 1993 reforms were repealed. Roger Stark, *Overview of the Individual Health Insurance Market in Washington State* (Jan. 2011).[5]

All of that evidence underscores the very real likelihood that implementation of ACA's market reforms in the absence of the individual mandate would confound the legislation's central goal of increasing the availability of affordable health care coverage. Congress, moreover, enacted the individual mandate in conjunction with its market reforms because it was acutely aware of the widespread difficulties that had arisen from the efforts of States to implement similar insurance market reforms without the economic counterbalance of an individual mandate. *See* 42 U.S.C. § 18091(a)(2)(I) ("[I]f there were no [mandate] requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.").

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[5] Other States that enacted market reforms in the 1990s experienced similar destabilization. *See* Kirk, *supra*, at 158, 167-168 (Kentucky and Massachusetts); Alexander K. Feldvebel & David Sky, *A Regulator's Perspective on Other States' Experiences*, 25 J. Health Politics, Policy & Law 197, 198-199 (2000) (New Hampshire); Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Policy & Law 71 (2000) (New York); Elliott K. Wicks, *The Individual Market in Vermont: Problems and Possible Solutions* (Dec. 2006) (prepared for Vermont Department of Banking, Insurance, Securities and Health Care Administration).

In determining whether Congress would "have been willing * * * to enact," *Pollock*, 158 U.S. at 636, ACA without an individual mandate, the Eleventh Circuit's severability analysis failed to grapple with the implications of that experiential history and the proven, substantial risk of profound economic displacement and a "market-wide antiselection spiral."[6] Directing the parties to brief the severability issue, however, would give the Court the benefit of comprehensive analysis and consideration of all the pertinent factors in determining whether or not Congress would have enacted ACA's market reforms in the absence of the individual mandate provision.

C. Severability Is a Question of Surpassing Importance and Its Prompt Resolution Is of Paramount Importance to the Health Care Industry

Should this Court determine that the individual mandate exceeds congressional power (a question on which AHIP takes no position), then the instability and uncertainty surrounding the question of the mandate's severability and the scope of constitutional invalidation would be every bit as economically destabilizing and suffocating for business planning as the current uncertainty surrounding the legality of the mandate itself. The difference between developing measures to implement a mandate-less ACA (i) with market reforms intact, and (ii) without some or many of those market reforms is night and day.

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[6] David Sky, *High Risk Pool Alternatives: A Case Study of New Hampshire's Individual Health Insurance Market Reforms*, 16 J. Ins. Reg. 399, 401 (Summer 1998).

AHIP's request that this Court order briefing focused on the severability question thus is an honest reflection of the imperative for the insurance industry that severability be resolved now, rather than remanded or even postponed until the next Term. Any delay would deprive businesses and consumers of desperately needed certainty about the profound changes in health care adopted by ACA until, in all likelihood, less than a year before the market reforms' effective date on January 1, 2014. *See* U.S. Consolidated Response Br. 10-11 (noting the "importance of severability issues in this case" and urging review). AHIP accordingly respectfully requests that this Court ensure that any resolution of the constitutional challenge to the individual mandate this Term offer a viable measure of certainty and closure to these debates, rather than perpetuate business instability and confusion for both member companies and their customers.

CONCLUSION

For the foregoing reasons, this Court should grant review of the single question presented in No. 11-393, the first question presented in No. 11-398, and the third question presented in No. 11-400.

Respectfully submitted.

Joseph Miller
Julie Simon Miller
AMERICA'S HEALTH
INSURANCE PLANS
601 Pennsylvania
Avenue, N.W.
South Building, Suite
500
Washington, DC 20004
(202) 778-3200

Patricia A. Millett
Counsel of Record
Kevin R. Amer
AKIN, GUMP, STRAUSS,
HAUER & FELD LLP
1333 New Hampshire
Avenue, N.W.
Washington, DC 20036
(202) 887-4000
pmillett@akingump.com

October 25, 2011

AMICUS
CURIAE
BRIEF

Supreme Court, U.S.
FILED
OCT 25 2011
OFFICE OF THE CLE

No. 11-400

IN THE
Supreme Court of the United States

FLORIDA, *ET AL.*,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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BRIEF OF *AMICI CURIAE* ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, JANIS CHESTER, M.D., MARK J. HAUSER, M.D., LEAH S. MCCORMACK, M.D., GUENTER L. SPANKNEBEL, M.D., AND GRAHAM L. SPRUIELL, M.D., IN SUPPORT OF PETITIONERS

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608
aschlafly@aol.com

DAVID P. FELSHER
Counsel of Record
488 MADISON AVE.
NEW YORK, NY 10022
(212) 308-8505
dflaw@earthlink.net
Counsel for Amici

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

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QUESTIONS PRESENTED

1. Does severance of the individual mandate of Section 1501 from the remainder of the Patient Protection and Affordable Care Act amount to a judicial line item veto that violates the Bicameral Clause?

2. Does simultaneous enactment and revision of Section 1501 violate the Presentment Clause?

3. Does the Commerce Clause require a dyadic transaction?

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No. 11-400

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INTEREST OF *AMICI CURIAE*[1]

Amici Curiae ("*Amici*") are individual physicians and a national association of physicians. *Amici* file this brief to assist the Court in defining the issues for review by this Court in the above captioned Petition.

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[1] This brief is filed with the filed written consent of all parties, with timely notice provided in compliance with Sup. Ct. Rule 37.2(a). Pursuant to Sup. Ct. Rule 37.6, counsel for *amici curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amici*, members of *amicus* AAPS, or *amici*'s counsel make a monetary contribution to the preparation or submission of this brief.

Since 1943, *Amicus* Association of American Physicians and Surgeons, Inc. ("AAPS") has been dedicated to the highest ethical standards of the Oath of Hippocrates and to preserving the sanctity of the patient-physician relationship. AAPS has filed numerous *amicus curiae* briefs in noteworthy cases like this one. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 933 (2000) (citing an AAPS *amicus* brief). Because AAPS has also commenced an action against one of the Petitioners which contains overlapping allegations of unconstitutionality, the disposition of this Petition may affect the rights of AAPS and its members. *Association of American Physicians and Surgeons, Inc. v. Sebelius*, Case No. 1:10-cv-0499-ABJ (D.D.C.).

Amicus Leah S. McCormack, M.D., privately practices dermatology in New York City, New York. She earned certification from the American Board of Dermatology and is a fellow of the American Academy of Dermatology. She is the immediate Past-President of the Medical Society of the State of New York.

Amicus Guenter L. Spanknebel, M.D., privately practiced gastroenterology. He is a Past-President of the Massachusetts Medical Society and is currently chair of its History Committee. He has served as a Trustee of the Health Foundation of Central Massachusetts and on the faculties of the medical schools at Tufts University and the University of Massachusetts.

Amicus Janis Chester, M.D., privately practices psychiatry in Delaware, serves as chair of the Department of Psychiatry at a community hospital, is a member of the faculty at Jefferson Medical College and holds a variety of positions with organized medicine and psychiatry, locally and nationally.

Amicus Mark J. Hauser, M.D. privately practices psychiatry and forensic psychiatry in Massachusetts and Connecticut.

Amicus Graham Spruiell, M.D., privately practices forensic psychiatry and psychoanalysis in the Boston area.

Amici have followed attempts in recent years to enact health care reform legislation. As active members of the medical profession and pursuant to their ethical obligations, *Amici* have carefully studied the introduction, passage and partial early implementation of the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010) ("ACA"), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010) ("HCERA" or "Reconciliation Act").

For the reasons set forth below, *Amici* believe that the Eleventh Circuit correctly held that Section 1501 is unconstitutional, but incorrectly severed Section 1501 from the remainder of ACA. *Amici* believe that ACA undermines, in fundamental and dangerous ways, the practice of medicine and harms patients. *Amici* expect *certiorari* to be granted because three separate petitions have been filed by the parties in this case.[2] Those petitioning parties include: (1) three departments of the federal government[3] and their corresponding Secretaries[4] ("Federal Petitioners") in Case No. 11-398; (2) a majority of the States ("State Petitioners")[5] in Case No. 11-400; and (3) three private parties ("Private Petitioners")[6] in Case No. 11-393. Consequently, if *certiorari* is granted in any of these cases, *Amici* respectfully suggest that the Court reconsider its approaches to the Commerce Clause, U.S. CONST. art. I, sec. 8, cl. 3 ("Commerce Clause"), and to severability. Thus, *Amici* submit this brief to provide the Court with greater clarity on those issues and to suggest that a statutory provision may not be enacted and amended simultaneously.

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[2] The decision of the Eleventh Circuit has been included in the Petitioner's Appendix ("Pet. App.") to Petition No. 11-398 at pages 1a-273a ("*Florida v. HHS*").

[3] United States Departments of the Treasury, Labor, and Health and Human Services.

[4] Timothy F. Geithner, Hilda L. Solis, and Kathleen Sebelius, respectively.

ARGUMENT

I. *CERTIORARI* SHOULD BE GRANTED BECAUSE THE SEVERABILITY INVOKED BELOW OPERATES AS A JUDICIAL LINE ITEM VETO IN VIOLATION OF THE BICAMERAL CLAUSE.

As this Court knows, the District Court concluded that the individual mandate of Section 1501 is not severable from the remainder of ACA and declared ACA invalid in its entirety, Pet. App. at 3a, 363a-64a, 366a. In contrast, the Eleventh Circuit concluded that the individual mandate of Section 1501 is severable from ACA. Pet. App. at 5a, 185a-86a, 188a. Although these courts both performed the traditional severability test they came to different conclusions. This Court should review the severability issue *de novo* and reconsider its test for severability.

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[5] Florida, South Carolina, Nebraska, Texas, Utah, Louisiana, Alabama, Michigan, Colorado, Pennsylvania, Washington, Idaho, South Dakota, Indiana, North Dakota, Mississippi, Arizona, Nevada, Georgia, Alaska, Ohio, Kansas, Wyoming, Wisconsin, Maine, and Iowa.

[6] National Federation of Independent Business, Kaj Ahlburg, and Mary Brown.

The traditional test for severability is well-known:

> "The standard for determining the severability of an unconstitutional provision is well established: Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *Alaska Airlines v. Brock*, 480 U.S. 678, 684 (1987) (internal quotation marks omitted). While the Act itself contains no statement of whether its provisions are severable, "[i]n the absence of a severability clause,... Congress' silence is just that – silence – and does not raise a presumption against severability." *Id.* at 686....

New York v. United States, 505 U.S. 144, 186 (1992). As a matter of logic and judicial consistency, Congressional silence should not raise a presumption favoring severability. Therefore, *Amici* question the presumption of severability used by the Eleventh Circuit. The Eleventh Circuit stated:

> In analyzing [the severability of the individual mandate of Section 1501 from ACA,] we start with the settled premise that severability is fundamentally rooted in a respect for separation of powers and notions of judicial restraint. *See Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 329-30 [(2006)]. Courts must "strive to salvage" acts of Congress by severing any constitutionally infirm provisions "while leaving the remainder intact." *Id.* at

> 329... "[T]he presumption is in favor of severability. *Regan v. Time, Inc.*, 468 U.S. 641, 653 [1984].

Pet. App. at 172a.[7]

Amici challenge the "notion" that severance is an act of judicial restraint. Rather, *Amici* ask the Court to consider that severance of the individual mandate of Section 1501 from ACA would be an act of judicial activism at its zenith, not its nadir, because such severance amounts to a judicial line item veto in that it allows the Judiciary to determine the content of a law after it has been enacted. Therefore, severance is a doctrine of judicial activism that allows, and possibly even encourages, constitutional sloppiness by Congress and the President.

Although *Amici*, like the State Petitioners and Private Petitioners, believe that the individual mandate of Section 1501 is not severable from ACA under the existing severability standard, *Amici* also believe that unless Congress enacts a severability clause as part of a statute, the Bicameral Clause deprives courts of power to sever any provision found to be unconstitutional. U.S. CONST. art. I, sec. 1, cl. 1 ("Bicameral Clause") ("All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives").

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[7] The Eleventh Circuit stated: "In the overwhelming majority of cases, the Supreme Court has opted to sever the constitutionally defective provision from the remainder of the statute." *Florida v. HHS*, 648 F.3d 1235, 1321 (11th Cir. 2011), Pet. App. at 172a-173a (citations omitted). The Eleventh Circuit supports its analysis with references to the House and Senate drafting manuals. 648 F.3d at 1322, Pet. App. at 175a-176a ("First, both the Senate and House legislative drafting manuals state that, in light of Supreme Court precedent in favor of severability, severability clauses are unnecessary unless they specifically state that all or some portions of a statute should *not* be severed") (citations omitted, emphasis in original).

There is no reason to believe that the Constitution allows the Judiciary to retain a judicial line item veto because Presidential line item vetoes are unconstitutional, *Clinton v. City of New York*, 524 U.S. 417, 447-49 (1998), and Congressional vetoes are unconstitutional, *Immigration and Naturalization Service v. Chadha*, 462 U.S. 919, 959 (1983). Although this Court has previously severed defective provisions from federal statutes, *see e.g.*, *Alaska Airlines*, 480 U.S. at 697, that remedy should be unavailable to courts without a Congressionally enacted severability clause considering *Clinton and Chadha*. The Bicameral and Presentment Clauses require the House and Senate to pass precisely the same text – not a single word or punctuation may vary between the bills passed by each chamber. *See Clinton*, 524 U.S. at 448. The judiciary, like the President, has no power to rewrite a statute. Furthermore, the idea that the judiciary be joined with the executive in a "council of revision" was considered and expressly rejected by the Drafters of the Constitution. Brief of Senators Robert C. Byrd, Daniel Patrick Moynihan, and Carl Levin as *Amici Curiae* in Support of Appellees 9-10 in *Clinton v. City of New York* (Docket No. 97-1374). The Constitution's Bicameral Clause gives "ALL" legislative power to Congress. Because the power to sever is the power to determine the content of legislation it may not be exercised by the courts.

It is clear from the Presentment Clause and as held in *Clinton* that partial vetoes are not permitted.

This *in toto* requirement was understood by Presidents Washington[8] and Taft[9] as well as the late Senator Moynihan,[10] a noted constitutional scholar. The *in toto* requirement should apply to the deconstruction of a statute by the courts in the same way that it applies to the deconstruction of a statute by the President.

The dangers of a legislature ceding its power to others are real. Over a five month period, Senator Byrd lectured his colleagues that ceding the Senate's power to control the content of a statute is analogous to actions taken by the Roman Senate which ultimately led to the decline and fall of the Roman Empire. 139 Cong. Rec. S 5475-79, 5724-27, 5975-78, 6395-98, 6982-85, 7157-60, 7539-42, 8157-60, 8582-85, 9097-9100, 9786-89, 10971-75, 11953-56, 13561-65 (103rd Cong., 1st Sess. 1993).

In light of *Clinton*, *Amici* strongly urge the Court to reconsider its approach to severability.

Furthermore, application of the existing severability standard is impractical, if not impossible, in this case. The Court would have to consider Section 1501's relationships with each of ACA's other provisions as well as various combinations of ACA's other provisions.[11] To illustrate this point, consider that there are 511 possible relationships among the nine Justices of this Court.[12] Assuming *arguendo* ACA contains 450 separate provisions (as recognized by the District Court), a court might have to consider as many as $2^{449} - 1$ separate relationships among ACA's remaining provisions to conduct a thorough severability analysis.[13] Courts lack the time, manpower and computer resources to conduct such an analysis.

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[8] *Accord* Letter from George Washington to Edmund Pendleton (Sept. 23, 1793), *reprinted in* 33 The Writings of George Washington 94, 96 (John C. Fitzpatrick, ed. 1940) ("From the nature of the Constitution, I must approve all the parts of a Bill, or reject it in toto"). President Washington also served as President of the 1787 Convention that promulgated the Constitution.

[9] William H. Taft, *The Presidency: Its Duties, Its Powers, Its Opportunities and Its Limitations*, at 11 (1916) (The President "has no power to veto part of the bill and allow the rest to become a law "). President Taft also served as Chief Justice of this Court.

[10] *See* 141 Cong. Rec. S4443-4449 (104th Cong., 1st Sess. 1995).

In addition to violating the Constitution's letter and spirit, the practice of severing a defective provision from a statute lacking a severability clause is bad policy because: (1) it facilitates legislative sloppiness – a bill's author knows the constitutionality of its provisions will be addressed piecemeal; (2) it allows judicial activism - a court can substitute its own judgment for the legislative bargain that was struck in Congress and agreed to by the President;[14] and (3) it encourages omnibus legislation – which members of Congress may not have sufficient time to read and understand prior to casting their votes.[15]

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[11] Tom Campbell, *Severability of Statutes*, 62 Hastings L. J. 1495, 1507-08, 1525 (July 2011) (concluding that *Chadha* and *Clinton* require a conclusive presumption of inseverability).

[12] Calculated by adding together the number of 1, 2, 3, 4, 5, 6, 7, 8, and 9 Justice combinations. That sum equals $2^9 - 1$.

[13] This number can be expressed with approximately 135 digits – which is 35 digits longer than the number googol, which is one followed by one hundred zeros.

[14] Congress, like other legislatures, is an institution that is conducive to vote trading and log-rolling activities. To enact a law, a majority coalition must be formed. Consequently, members of Congress often cooperate to further an individual or collective agenda. Passage of a bill might require the vote of a single member of Congress or Senator. If ACA had contained a severability clause, the legislative bargain made by members of Congress probably would not have been reached. Indeed, a severa-

Regardless of the deference accorded to Congress, this Court may not sever a defective provision from a statute in the absence of a severability clause because such severance is a judicial line item veto. This practice substantially alters the dispersion of powers incorporated into the Constitution. It is time to return "all legislative power" to Congress as required by the Constitution's first clause. U.S. CONST. art. I, sec. 1, cl. 1.

II. THE COMMERCE CLAUSE IS NOT TRIGGERED BECAUSE SECTION 1501 LACKS "COMMERCE" DUE TO THE ABSENCE OF INVOLVEMENT BY TWO PARTIES.

The Federal Petitioners' Commerce Clause argument fails and should not be addressed by the Court because the individual mandate of Section 1501 does not involve any commerce. The plain language and structure of article I, section 8 make this absolutely clear. Under clause 3, the power is "to regulate" and the object of that power is "commerce". The Constitu-

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bility clause was included in an early version of H.R. 3590, but was excluded from ACA, as enacted.

[15] The Presentment Clause directs "reconsideration" of vetoed bills - implicitly requiring members of Congress to actually "consider" a bill. The lack of "consideration" is apparent since it took almost two months after ACA and HCERA were enacted for the Office of Legislative Counsel of the House of Representatives to produce its ACA Compilation Report and for Ernst & Young, one of the Big 4 accounting/consulting firms to issue its summary of the statutes, E&Y Summary. *See infra* n.17.

tion does not give Congress power to regulate all commerce. Rather, the Constitution restricts Congress to regulating a set of only three types of commerce: (1) "with" foreign Nations; (2) "among" the several States; and (3) "with" the Indian Tribes. U.S. CONST. art. I, sec. 8, cl. 3. All three members of this set necessarily involve at least a dyad or pair of parties. Without two or more parties, the words "with" and "among" are meaningless.

Therefore, in deciding this matter, the Court should undertake a two-step analysis. First, it should determine if Congress attempted to regulate "commerce." Only if this question is answered affirmatively should the Court undertake step two, an analysis of the "interstate commerce" sub-clause. Petitioners have addressed only step two. They have ignored step one. Consequently, the Federal Petition (11-398) should be rejected.

With regard to step one, the key is to understand that "commerce" may be viewed as the interrelationship, traffic, agreement or transaction between parties. For example, we may see vendors paired with vendees; sellers paired with buyers; lessors paired with lessees; borrowers paired with lenders; and debtors paired with creditors. Expressed in mathematical terms, "commerce" is Euclid's line between two points or Einstein's interval between two points on an ideal rigid body, where the points represent the two parties and the line or interval represents the commercial transaction, agreement, traffic or interrelationship. Euclid, *Elements of Geometry* 6 (Greek Text of J.L. Heiberg (1883-1885)) (R. Fitzpatrick, ed. & translator) ("And the extremities of a line are points"); Albert Einstein, *The Meaning of Relativity* 4 (5th ed. 1956) (posthumously).

This Court has long understood and still understands that "commerce", by definition, necessarily involves two or more parties, *i.e.*, a party and a counterparty. *See United States v. Lopez*, 514 U.S. 549, 553 (1995); *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 194-95 (1824) (Marshall, C.J.).

III. THE PRESENTMENT CLAUSE WAS VIOLATED BY SECTION 1501 BECAUSE IT WAS SIMULTANEOUSLY ENACTED AND AMENDED.

Congress simultaneously enacted Sections 1501 and 10106 of ACA, but such simultaneity is not permitted by the Constitution. Accordingly, the Court need never address the Commerce Clause argument proffered by the Federal Petitioners. Section 1501 creates 26 U.S.C. §5000A, 124 Stat. at 244, which defines "penalty amount," while Section 10106 simultaneously changes the definition in 26 U.S.C. §5000A, 124 Stat. at 909.

Congress may not simultaneously enact and revise any provision within the same statute because such simultaneity violates the Presentment Clause, the "single, finely wrought and exhaustively considered, procedure" which is used to enact Federal legislation. *Chadha*, 462 U.S. at 951; *Clinton*, 524 U.S. at 439-440.

"[R]epeal of statutes, no less than enactment, must conform to Art. I." *Clinton*, 524 U.S. at 438. The same principle applies to revisions and amendment of statutes. Consequently, 26 U.S.C. §5000A could not and should not have been enacted and revised within the same statute. This unconstitutional practice completely infects ACA. Indeed, pursuant to

Title X, Congress attempted to amend scores of other ACA provisions that were simultaneously enacted.[16]

During debate over the Constitution's ratification, James Madison stated laws should be understandable, not too long, and "not be revised before they are promulgated." THE FEDERALIST No. 62, at 381 (Madison) (C. Rossiter, ed. 1961). He wrote:

> The internal effects of a mutable policy are still more calamitous. It poisons the blessings of liberty itself. It will be of little avail to the people that the laws are made by men of their own choice if the laws be so ***voluminous that they cannot be read, or so incoherent that they cannot be understood; if they be repealed or revised before they are promulgated***, or undergo such incessant changes that no man, who knows what the law is today, can guess what it will be tomorrow. Law is defined to be a rule of action; but how can that be a rule, which is little known, and less fixed?

Id. (emphasis added). Congress ignored Madison's warning and passed H.R. 3590, a 2400 page bill, which became ACA upon the President's signature. Within days of passing ACA, Congress also passed H.R. 4872 which further amended ACA and became the Reconciliation Act.

Although simultaneously enacting and revising 26 U.S.C. §5000A may have led to needless complexity, incongruity, and ambiguity for our citizenry and judiciary, the critical constitutional problem is that both the original and revised versions of Section 5000A were presented to the President at the same time. In fact, 26 U.S.C. §5000A did not exist at the times the House and Senate passed H.R. 3590 nor did it exist when H.R. 3590 was presented to the President. Consequently, Section 10106 merely attempts to amend a nullity. For 26 U.S.C. §5000A to be revisable, Section 10106 must be enacted after section 1501, not simultaneously with it.

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[16] 124 Stat. at 883-1024.

Furthermore, given ACA's length and the number of simultaneously enacted and amended provisions, James Madison surely would have considered ACA too long and too incoherent to be understood. Indeed, ACA's length and complexity did not go unnoticed by the District Court. "[ACA], as previously noted, is obviously very complicated and expansive. It contains about 450 separate provisions with different time schedules for implementation." Order, dated March 3, 2011, Pet. App. at 388a; *see also* Michael O. Leavitt, "Health reform's central flaw: Too much power in one office," Washington Post (February 18, 2011) (referring to nearly 2000 powers given to the HHS Secretary by ACA). Further attesting to ACA's complexity and its internal changes is Print No. 111-1 of the United States House of Representatives, a 955 page report produced by the Office of Legislative Counsel for use by the United States House of Representatives almost two months after ACA and HCERA were enacted.[17] This report, which highlights and explicitly references many of ACA's internal amendments, would have been of great help to members of Congress before they voted on ACA and HCERA.

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[17] Office of the Legislative Counsel, United States House of Representatives, 111th Cong.. 2d Sess., Compilation of Patient Protection and Affordable Care Act [As Amended Through May 1, 2010] at 833 *et seq*. ("ACA Compilation Report") *available at* http://docs.house.gov/energycommerce/ppacacon.pdf (viewed 10/23/11). *See also* Ernst & Young, LLP, Summary of the Patient Protection and Affordable Care Act, incorporating The

CONCLUSION

For the foregoing reasons, Petition 11-400 (and the related Petition 11-393) should be granted, and the related Petition 11-398 should be denied.

October 25, 2011

Respectfully submitted,

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608
aschlafly@aol.com

DAVID P. FELSHER
Counsel of Record
488 MADISON AVENUE
NEW YORK, NY 10022
(212) 308-8505
dflaw@earthlink.net

Counsel for Amici

Health Care and Education Reconciliation Act (May 2010) (This summary is 159 pages long) ("E&Y Summary").

AMICUS
CURIAE
BRIEF

No. 11-400

In the

Supreme Court of the United States

STATES OF FLORIDA, et al.,

Petitioners,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES , et al.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* CENTER FOR CONSTITUTIONAL JURISPRUDENCE, PACIFIC LEGAL FOUNDATION, AND MATT SISSEL IN SUPPORT OF PETITIONERS

EDWIN MEESE III
214 Massachusetts Ave. N.E.
Washington D.C. 20002

TIMOTHY SANDEFUR
Pacific Legal Foundation
930 G Street
Sacramento, CA 95814
(916) 419-7111
tsandefur@pacificlegal.org

JOHN C. EASTMAN
Counsel of Record
ANTHONY T. CASO
KAREN J. LUGO
Center for Constitutional Jurisprudence
c/o Chapman Univ. Sch. of Law
One University Drive
Orange, California 92886
(714) 628-2587
jeastman@chapman.edu

Counsel for Amici Curiae

QUESTION PRESENTED

1. Against the backdrop of a federal spending program the constitutionality of which is both dubious and untested, does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress's spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?

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INTEREST OF AMICI CURIAE[1]

Amicus the Center for Constitutional Jurisprudence was established in 1999 as the public interest law arm of the Claremont Institute, the mission of which is to uphold and restore the principles of the American Founding to their rightful and preeminent authority in our national life, including the foundational proposition that the powers of the national government are few and defined, with the residuary of sovereign authority reserved to the states or to the people. In addition to providing counsel for parties at all levels of state and federal courts, the Center and its affiliated attorneys have participated as amicus curiae or on behalf of parties before this Court in several cases addressing the constitutional limits on federal power, including *American Elec. Power Co., Inc. v. Connecticut*, 131 S.Ct. 2527 (2011); *Bond v. United States*, 131 S.Ct. 2355 (2011); *Reisch v. Sisney*, No. 09-953, *cert. denied*, 130 S.Ct. 3323 (2010); *Rapanos v. United States*, 547 U.S. 715 (2006); *GDF Realty Investments, Ltd. v. Norton*, No. 03-1619, *cert. denied*, 545 U.S. 1114 (2005); *Rancho Viejo, LLC v. Norton*, No. 03-761, *cert. denied*, 540 U.S. 1218, *reh'g*

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[1] Pursuant to this Court's Rule 37.2(a), all parties have consented to the filing of this brief. Letters evidencing such consent have been filed with the Clerk of the Court. Counsel of record for all parties received notice at least 10 days prior to the due date of the Amici Curiae's intention to file this brief. Pursuant to Rule 37.6, *Amici Curiae* affirm that no counsel for any party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *Amici Curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

denied, 541 U.S. 1006 (2004); *Solid Waste Agency of Northern Cook County v. U.S. Army Corps of Engineers*, 531 U.S. 159 (2001); *Schaffer v. O'Neill*, No. 01-94, *cert. denied*, 534 U.S. 992 (2001); and *United States v. Morrison*, 529 U.S. 598 (2000).

Amicus Pacific Legal Foundation ("PLF") is widely recognized as the largest and oldest nonprofit legal foundation representing the views of thousands of supporters nationwide who believe in limited government, individual rights, and federalism. PLF has participated as amicus curiae in several lawsuits challenging the constitutionality of the Patient Protection and Affordable Care Act (PPACA), including *Virginia ex rel. Cucinelli v. Sebelius* (No. 11-420, pending); *Seven-Sky v. Holder*, No. 11-5047 (D.C. Cir., pending); and *Coons v. Geithener*, No. CV-10-1714 (D. Ariz., pending). In addition, PLF attorneys represent amicus Matthew Sissel, a citizen of Iowa, and decorated Iraq War veteran and small business owner, who is the plaintiff in a lawsuit challenging the constitutionality of PPACA, *Sissel v. U.S. Dep't of Health & Human Servs.*, No. 1:10 cv 01263 RJL (D.D.C., filed July 26, 2010).

SUMMARY OF ARGUMENT

Talk about the proverbial camel's nose under the tent! What began with the small step of upholding a federal program to stop the "spread" of great depression-era unemployment from State to State has now metastasized into a wholesale usurpation of the police power, that power to regulate the health and safety of the people which this Court has correctly and repeatedly recognized is reserved to the States. Just as the Commerce Clause power has outer limits—and we fully endorse both the holding of the Eleventh Circuit below on that score and the claim in the parallel petitions of the States and the National Federation of Independent Business that the circuit split that has developed on that issue warrants this Court's review[2]—the Spending Clause also has limits that warrant this Court's consideration. *United States v. Butler*, 297 U.S. 1 (1936). But the increasing tendency of the courts to effectively treat Spending Clause issues as non-justiciable political questions has facilitated Congress's spending addiction, to the point that a graph of the extraordinary, rapid and exponential rise in the national debt in recent years makes the infamous global warming "hockey stick" graph look positively modest.[3]

Our nation's Founders never envisioned unfettered spending by the Congress, and when the political branches prove incapable of policing themselves, it is the solemn duty of this Court to check their constitutional excesses. A wholesale revisiting of the New Deal precedents that approved digging of the unconstitutional spending hole in which we find ourselves is not now required, but we at least must stop digging. The massive expansion in the assertion of federal authority upon which rests the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 ("PPACA"), begs for a response from this Court to reestablish the most basic of constitutional premises, that ours is a national government of limited, delegated power.

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[2] As a result, we support both the State Petitioners' Petition for a Writ of Certiorari in No. 11-400 and the NFIB's Petition for a Writ of Certiorari in No. 11-393.

[3] *Compare* Michael E. Mann and Raymond S. Bradley, *Northern Hemisphere Temperatures During the Past Millenium: Inferences, Uncertainties, and Limitations*, American Geophysical Union, Geophysical Research Letters, v. 3.1 (Feb. 14, 1994), *available at* http://www.ncdc.noaa.gov/paleo/pubs/millennium-camera.pdf (last visited Oct. 30, 2011), *with* Chart, U.S. Federal Debt from FY 1900 to FY 2016, *available at* http://www.usgovernmentspending.com/spending_chart_1900_2016USk_13s1li0181151_613cs_H0f_US_Federal_Debt (last visited Oct. 30, 2011).

The States' challenge under *South Dakota v. Dole*, 483 U.S. 203 (1987), to the coerciveness of the federal spending conditions would be a good place to start. By developing a "coercion" jurisprudence that focuses less on the amount of the money at stake—although it is hard to imagine a scenario less problematic under that calculus than the current one—and more on federalism and the nexus with permissible constitutional ends, this Court could begin to reconcile current spending practice with its holding in *Butler* and with the admonition in *United States v. Lopez*, 514 U.S. 549, 557 (1995), that there must be "outer limits" on congressional authority.

ARGUMENT

I. THIS CASE PRESENTS THE OPPORTUNITY TO REAFFIRM THAT THE SPENDING CLAUSE, LIKE THE COMMERCE CLAUSE, HAS OUTER LIMITS.

A. Spending Clause Jurisprudence Since *Butler* Has Not Paid Sufficient Heed to the "Outer Limits" of Constitutional Authority.

The history of Spending Clause jurisprudence since this Court decided *United States v. Butler* in 1936 is a perfect example of a "camel's nose" argument that actually proves to be true rather than fallacious.[4] First, Title III of the Social Security Act of 1935, 42 U.S.C. § 501 *et seq.*, was upheld by this Court in 1937 (after external pressure threatened the Court's composition and independence[5]) because it was limited to unemployment benefits, and unemployment was "[s]preading from state to state," thus necessitating a national solution. *Charles C. Ste-*

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[4] There are many iterations of the "camel's nose in the tent" story, some using it to describe negative consequences that come about incrementally, others using the story to describe the logical fallacy of some slippery slope arguments. Although the version of the story found at http://www.thewisdomjournal.com/Blog/the-verbal-cheap-shot-artist-part-ten-the-camels-nose/ is of the latter sort, we quote from it in the text which follows because of the richness of its narrative, simply noting that sometimes, as here, the slippery slope really does exist. *See generally*, Eugene Volokh, *The Mechanisms of the Slippery Slope*, 116 Harv. L. Rev. 1026 (2003).

[5] *See, e.g.*, Barry Cushman, *Rethinking the New Deal Court*, 80 Va. L. Rev. 201, 202 n.1 (1994).

ward Mach. Co. v. Davis, 301 U.S. 548, 586-87 (1937) ("*Steward*"); *Helvering v. Davis*, 301 U.S. 619, 641 (1937) (*citing Home Bldg. & Loan Ass'n v. Blaisdell*, 290 U.S. 398, 442 (1934)).

Truth be told, there was no constitutional analysis in the *Steward* opinion. The Court merely noted that "[i]t is too late today for the argument to be heard with tolerance that in a crisis so extreme [as the great depression] the use of the moneys of the nation to relieve the unemployed and their dependents is a use for any purpose narrower than the promotion of the general welfare." In support of that *ipse dixit*, the Court provided a "cf." citation to *Butler*, 297 U.S. at 65, 66, which just the year before had *struck down* the Agricultural Adjustment Act, 48 Stat. 31 (May 12, 1933), as going beyond the authority of the general welfare clause because it did not further a purpose entrusted to the national government.[6] *Butler*, 297 U.S., at 78. How "unemployment" is any more a purpose entrusted to the national government than "agriculture," the *Steward* Court did not say.

"Master, can I just put my nose into the tent to warm up?" said the camel to his Bedouin master, who begrudgingly agreed.

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[6] The Court also cited *Helvering v. Davis*, 301 U.S. 619, 672 (1937), decided the same day, but *Helvering* itself adds nothing to the analysis, merely stating that the question of the constitutionality of the retirement provisions of the Social Security Act was similar to that of the unemployment provisions, already decided in the *Steward* case. Rarely has there been greater circularity of reasoning in the pages of the U.S. Reports.

The same day, the Court extended the ruling from unemployment to retirement benefits, citing as authority the aforementioned *Butler* and, circularly, *Steward*. Here is the full extent of the analysis: "Spreading from state to state, unemployment is an ill not particular but general, which may be checked, if Congress so determines, by the resources of the nation. . . . But the ill is all one or at least not greatly different whether men are thrown out of work because there is no longer work to do or because the disabilities of age make them incapable of doing it." *Helvering*, 301 U.S. at 641. No difference between being unemployed because one was laid off and "unemployed" because one had retired? Despite the obvious difference between the two, Title II of the Social Security Act, 42 U.S.C. § 401 *et seq.*,?? was also upheld.

"Master, can I just put my forelegs into the tent? They're freezing," the camel successfully pleaded.

Thirty years later, Congress decided to enter the health care arena, another realm that had traditionally been viewed as exclusively within the sovereign authority of the States. So pervasive had become the view that the General Welfare Clause provided no limits on Congress, *Butler* to the contrary notwithstanding, that the 1965 Medicare and Medicaid Amendments to the Social Security Act[7] do not appear to have ever faced a constitutional challenge. If providing both unemployment benefits and old age pensions was permissible because taking care of the needy was in the *general* welfare rather than the concern of the individual states, then providing health care benefits for the poor (Medicaid) and aged (Medicare) must also be permissible, the original rationale that unemployment was "spreading" from one state to another having long since been forgotten.

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[7] Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 102(a), 121(a), 1965 U.S.C.C.A.N. (79 Stat. 286, 291, 343) 305, 311, 370 (amended 1967) (codified as amended at 42 U.S.C. §§ 1395c to 1395w-4, 1396 to 1396v).

And the camel said, "I have to put my back legs in as well, otherwise they will freeze and we won't be able to travel in the morning."

We know how the camel story ends. The Bedouin master awakes in the middle of the night, completely outside the tent in the cold. As will we, if the camel is not stopped.

B. Basic Separation of Powers Principles Require This Court's Enforcement of Constitutional Limits on Spending Authority.

The Congress itself has a solemn duty to exercise power only within the limits of its constitutionally delegated authority. U.S. Const. Art. VI, cl. 3 ("The Senators and Representatives . . . shall be bound by Oath or Affirmation, to support this Constitution"). But, quite correctly recognizing that power tends not to police itself very well, our Founders provided a constitutional system in which legislative power could be checked by the other branches of government as well. *See, e.g.,* The Federalist No. 51, at 320 (Madison) (C. Rossiter, ed., 1961) (noting that the Constitution was designed so that "its several constituent parts may, by their mutual relations, be the means of keeping each other in their proper places"); The Federalist No. 78, at 467 (Hamilton) ("the courts were designed to be an intermediate body between the people and the legislature in order, among other things, to keep the latter within the limits assigned to their authority").

For more than a half century, Presidents performed that check admirably, through an effective use of the veto power. *See, e.g.*, Veto Message of President Madison, 30 ANNALS OF CONG., Senate, 14th Cong., 2nd Sess. 211 (1817); Veto Message of President Monroe, 39 ANNALS OF CONG., House of Representatives, 17th Cong., 1st Sess. 1838 (1822); Veto Message of President Jackson, 28 H.R. JOURNAL 29 (1834); Veto Message of President Buchanan (Feb. 24, 1859), *in* 7 A COMPILATION OF THE MESSAGES AND PAPERS OF THE PRESIDENTS 3079 (James D. Richardson ed., 1897). And another three quarters of a century after that, this Court did as well, invalidating a congressional spending program in *Butler* that did not further powers delegated to the national government. *See generally, e.g.*, John C. Eastman, *Restoring the "General" to the General Welfare Clause*, 4 Chap. L. Rev. 63 (2001); Robert G. Natelson, *The General Welfare Clause and the Public Trust: An Essay in Original Understanding*, 52 U. Kan. L. Rev. 1 (2003); David E. Engdahl, *The Spending Power*, 44 Duke L.J. 1 (1994).

Although *Butler* remains valid precedent, it is almost uniformly ignored in the lower courts, encouraged by this Court's lackluster commitment in *South Dakota v. Dole* to enforcing the constitutional limitation that spending must be for "purposes . . . of general, not local, national, not state, benefit." Veto Message of President Monroe, 39 ANNALS OF CONG., *supra*, at 1849; *see Dole*, 483 U.S. at 207 and n.2

(noting that "courts should defer substantially to the judgment of Congress" and questioning "whether 'general welfare' is a judicially enforceable restriction at all").

Yet the limitation is real; it is ascertainable; and as this case amply demonstrates, it must be enforced lest the carefully-wrought distinction between what is national and what is local be rendered null and void. As Justice Kennedy noted in his concurring opinion in *United States v. Comstock*, 130 S.Ct. 1949, 1967 (2010), "[t]he limits on the spending power have not been much discussed, but if the relevant standard is parallel to the Commerce Clause cases, then the limits and the analytical approach in those precedents should be respected." Certiorari is therefore warranted to consider (and reject) the government's on again/off again reliance on the Constitution's tax and spend power as a source of authority for the PPACA.[8]

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[8] The Court need not reconsider its prior decisions in *Steward* and *Helvering* in order to reject the massive additional slide down the slippery slope that the PPACA represents. Or, to stick with our original metaphor, the Court can decline to welcome the camel's hind quarters into the tent without forcibly removing its front legs and nose. But if the serious constitutional analysis that we request be undertaken in the present case yields a renewed recognition that the Spending Clause contains enforceable limits on the power of the federal government and hence might call into question some aspects of the holdings in those cases, there is precedent for long periods of weaning from the unconstitutional conduct to avoid societal disruption and to accommodate reliance interests. *Compare Brown v. Board of Ed. of Topeka, Kan.*, 349 U.S. 294, 301 (1955) ("Brown II") (ordering that school segregation be ended "with all deliberate speed"), *with Green v. County Sch. Bd. of New*

II. THE COERCION PRONG OF THE *DOLE* SPENDING CLAUSE ANALYSIS MUST BE GIVEN EFFECT.

Even if this Court determines that the present case is not the appropriate vehicle for confronting the broader Spending Clause issue itself, *cf. Reisch v. Sisney*, No. 09-953, *cert. denied*, 130 S.Ct. 3323 (2010); *Cutter v. Wilkinson*, 544 U.S. 709, 718 n.7 (2005); *id.* at 727 n.2 (Thomas, J., concurring) (noting that RLUIPA may well exceed Congress' authority under either the Spending Clause or the Commerce Clause"), the States' "coercion" claim should at least be considered against the broader Spending Clause backdrop. Indeed, one of the reasons the lower courts have had difficulty applying the "coercion" prong of *Dole* is that they have focused on the size of the federal largess (either in absolute terms or as a percentage of some funding program) in order to determine whether the federal government's grant of funds, and the strings attached to them, were unduly coercive. Viewed in isolation, some courts have found it hard to fathom how any "gift" of funds can be coercive. *See, e.g.*, *Nevada v. Skinner*, 884 F.2d

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Kent County, Va., 391 U.S. 430, 438 (1968) (noting, almost 15 years later, that "'[t]he time for mere 'deliberate speed' has run out'"); *cf. Grutter v. Bollinger*, 539 U.S. 306, 310 (2003) (noting respondents' pledge that it "will terminate its use of racial preferences as soon as practicable" and expecting "that 25 years from now" such use "will no longer be necessary"). Moreover, because the States in our constitutional system remain as they always have been—separate sovereigns with the principal authority for advancing the internal health and safety of their citizens—there is little risk that health care would fall into a governmental void.

445, 448–49 (9th Cir. 1989); *Kansas v. United States*, 214 F.3d 1196, 1202 (10th Cir. 2000).

But the "coercion" prong should not be viewed in isolation. It exists against a backdrop of a limited spending power, and in the context of federalism. When, as with the case of the expanded Medicare program under consideration here, the federal government grabs tax revenues from a State's own citizens, then returns some portion of those revenues to further police power purposes that fell within the State's jurisdiction in the first place, and attaches to that "gift" of federal funds some regulatory condition that the federal government could not impose directly, the transaction is inherently coercive. *See* Richard Epstein, *Bargaining With the State* 152 (1993); Lynn A. Baker, "*The Spending Power and the Federalist Revival,*" 4 Chap. L. Rev. 195, 224 (2001). As *Butler* recognized, "[t]here is an obvious difference between a statute stating the conditions upon which moneys shall be expended and one effective only upon assumption of a contractual obligation to submit to a regulation which otherwise could not be enforced." *Butler*, 297 U.S. at 73.

This is particularly true where, as here, the "gift" is massive and amounts to a large percentage of the total funds the State receives from the federal government. *See Com. of Va. Dept. of Educ. v. Riley*, 86 F.3d 1337, 1355-56 (4th Cir. 1996) (Luttig, J., dissenting), *adopted as the plurality opinion of the court on reh'g en banc*, 106 F.3d 559 (4th Cir. 1997) (holding that "a Tenth Amendment claim of the highest order lies where . . . the Federal Government . . . withholds the entirety of a substantial federal grant on the ground that the State refuses to fulfill their federal obligation in some insubstantial respect rather than submit to the policy dictates of Washington in a matter peculiarly within their powers as sovereign States.").

Certiorari is therefore warranted to resolve the split among the circuits over the ongoing vitality of the "coercion" prong of the *Dole* analysis, to give the doctrine enough jurisprudential heft to serve as a meaningful check on intrusive congressional action, and to place the doctrine squarely in the context of the concepts of federalism and limited, enumerated powers that need to be as much a part of the understanding of the Spending Clause as they are of the Commerce Clause.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

EDWIN MEESE III
214 Mass. Ave. NE
Washington, DC 20002

TIMOTHY SANDEFUR
Pacific Legal Foundation
930 G Street
Sacramento, CA 95814
(916) 419-7111
tsandefur@pacificlegal.org

JOHN EASTMAN
Counsel of Record
ANTHONY T. CASO
KAREN J. LUGO
Center for Constitutional Jurisprudence
c/o Chapman University School of Law
One University Drive
Orange, CA 92886
(714) 628-2587
jeastman@chapman.edu

Counsel for Amici Curiae

Dated: October 31, 2011.

AMICUS CURIAE BRIEF

Nos. 11-393, 11-398 & 11-400

IN THE
Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL., PETITIONERS
v.
KATHLEEN SEBELIUS, ET AL.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS
v.
STATES OF FLORIDA, ET AL.

STATES OF FLORIDA, ET AL., PETITIONERS
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

On Petitions for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF THE PETITIONS FOR CERTIORARI

(Counsel listed on inside cover)

ROBIN S. CONRAD
SHANE B. KAWKA
KATHRYN COMERFORD TODD
NATIONAL CHAMBER LITIGATION
CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

K. LEE BLALACK II
(Counsel of Record)
lblalack@omm.com
BRIAN D. BOYLE
ANTON METLITSKY
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

Attorneys for Amicus Curiae

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BRIEF OF *AMICUS CURIAE* CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA IN SUPPORT OF THE PETITIONS FOR CERTIORARI

This brief is submitted on behalf of the Chamber of Commerce of the United States of America in support of the petitions for certiorari.[1]

INTEREST OF *AMICUS CURIAE*

The Chamber of Commerce of the United States of America ("the Chamber") is the world's largest business federation, representing the interests of 300,000 direct members and indirectly representing an underlying membership of three million businesses and professional organizations of every size, in every industry sector, and from every region of the country. More than 96 percent of the Chamber's members are small businesses with one hundred or fewer employees. The Chamber advocates on issues of vital concern to the nation's business community and has frequently participated as *amicus curiae* before this Court and other courts. And in particular, the Chamber has participated as *amicus curiae* in litigation concerning the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 ("PPACA") in the

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[1] No counsel for any party has authored this brief in whole or in part, and no person other than *amicus*, its members, or its counsel have made any monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Supreme Court Rule 37.2, *amicus* states that all counsel of record for all parties were timely notified of the intent to file this brief; the parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

Courts of Appeals for the Fourth, Eleventh, and District of Columbia Circuits.

Resolution of the fate of the PPACA is of critical importance to Chamber members. The majority of the Chamber's members provide health insurance to their employees. Indeed, employers are the country's largest providers of health benefits, providing coverage for more than 160 million people and more than 60 percent of nonelderly Americans. More generally, the PPACA imposes a myriad of costly obligations on the business community—as well as on states and consumers. Uncertainty over the future of the PPACA seriously undermines the ability of American businesses to plan for the future, and to make informed decisions concerning investment in growth and hiring. Accordingly, both swift resolution of the constitutionality of the individual mandate, and clarification as to which portions of the PPACA, if any, will remain if the individual mandate falls, are crucial to Chamber members.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("PPACA" or "the Act"), contains an extensive set of reforms primarily intended to make health insurance available to millions of uninsured Americans and to increase the quality of health insurance for all Americans. The Act's insurance reforms are interdependent and built upon one central provision: the requirement to maintain minimum essential coverage under Section 1501.

PPACA, Pub. L. No. 111-148, § 1501(a), 124 Stat. 119, 244 (codified at 26 U.S.C. § 5000A(a)).

The individual mandate is indispensible to the operation of the PPACA's health insurance reforms. Congress understood that simply requiring insurers to provide coverage to all applicants at the same price without regard to their health status could not occur unless healthy individuals were also incented or required to purchase coverage. Standing alone, these new insurance requirements (the core of which is known as the guaranteed-issue and community-rating reforms) would lead to less affordable health insurance because individuals would wait to purchase health insurance until they absolutely need it, forcing insurers to raise premiums for everyone else. To prevent such behavior, often referred to as "adverse selection," Congress included a minimum essential coverage requirement in the PPACA—the so-called individual mandate.

By requiring individuals to maintain a minimum level of health insurance coverage, the law was drafted to prevent the adverse selection that would otherwise undermine the new insurance requirements. Through the individual mandate, the law was structured to allow guaranteed-issue, community-rating, and other insurance reforms to function without adverse selection, as Congress intended. The PPACA would not have been enacted without it. As Congress explained in the Act, the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that ... do not exclude coverage of preexisting conditions can be sold." 42 U.S.C. § 18091(a)(2)(I).

Although the Chamber takes no position on the constitutionality of the individual mandate,[2] there should be no dispute that the mandate's constitutional validity is a question of overriding national importance to the business community—as well as to the federal and state governments and to consumers. The circuit conflict that has developed concerning that question should be resolved by this Court in this case. The constitutionality of the mandate, however, is only the first half of the important issue at stake. The second half of the issue—of crucial importance to the business community and to the Nation as a whole—is whether, and to what extent, the remainder of the PPACA will remain in force if the individual mandate is invalidated.

The business community has a tremendous interest in assuring that, if the mandate is struck down, the fate of the remaining provisions of the Act is resolved quickly. Numerous PPACA provisions impose substantial requirements and costs on American businesses. As a result, businesses will have to change their practices and make important decisions to comply with the new requirements. But businesses cannot make rational decisions concerning how to comply with the law and budget for its costs without knowing what the law is and how it will be enforced and applied in the future. Certainty is necessary before businesses can make decisions concerning investment in growth and in jobs.

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[2] The Chamber also takes no position on whether the first and second questions presented in the petition for certiorari filed by several States, in case No. 11-400, should be granted, or on the merits of those questions.

Thus, the Chamber strongly urges the Court not to limit its review to the constitutionality of the mandate, but also to consider as a separate question which additional provisions of the PPACA are considered non-severable from the individual mandate, and thus fall with it, if the mandate is held unconstitutional. Putting off consideration of the severability question will only extend the cloud of uncertainty hanging over American businesses and our economy.

This Court's immediate review of the severability question is also critical because the Eleventh Circuit's incorrect severability decision will wreak havoc on the health insurance market if left to stand. While the court of appeals held the individual mandate unconstitutional, it further held that the mandate could be severed from the remainder of the Act. That position is untenable. If the PPACA's remaining insurance reform provisions were left standing in the absence of the mandate, individuals and employers who sponsor health insurance coverage for their employees would encounter real and significant market disruption. Health care costs would rise and fewer individuals would obtain coverage—precisely the opposite of Congress's intentions. A proper application of this Court's severability jurisprudence therefore requires a finding that, at the very least, the health insurance reform provisions in the PPACA are non-severable from the individual mandate and must necessarily fall with it.

For instance, the United States has explained that two of the principal health insurance reforms in the PPACA—the guaranteed-issue and community-rating reforms—would necessarily fall with the minimum coverage mandate. *See* Consolidated Brief for Respondents at 10, *Nat'l Fed'n of Indep. Bus. v. Sebelius* and *Florida v. Dep't of Health and Human Servs.* (Nos. 11-393 & 11-400) (U.S.) ("[T]he [Eleventh Circuit's] conclusion that the guaranteed-issue and community-rating provisions could be severed from the minimum coverage provision was incorrect."). In the absence of the mandate, individuals will have no reason to purchase insurance until they become sick, which will drive up insurance premiums for the remaining consumers. The increase in premiums would in turn cause healthy individuals to stop purchasing (or refrain from obtaining) health insurance, causing premiums to rise still further. This "premium spiral" has been experienced in various states—such as New York, Kentucky, and Washington—where similar health insurance reforms were enacted without an accompanying minimum coverage mandate. The legislative record confirms that Congress understood this market dynamic and would not have enacted guaranteed-issue and community-rating reforms in the absence of the individual mandate. Yet if the court of appeals' decision is allowed to stand, all the negative consequences that Congress sought to avoid by enacting the individual mandate would necessarily come to pass.

The Chamber also submits that the severability inquiry does not end with the guaranteed-issue and community-rating reforms alone. Rather, the other insurance reform requirements in the PPACA, beyond guaranteed-issue and community-rating, also depend on the existence of a fully insured marketplace. Invalidating the individual mandate while retaining these other provisions would similarly undermine the purpose of the Act and disrupt the market for health insurance.

At the certiorari stage, however, it is not necessary for the Court to conduct an in-depth severability analysis of the entire Act. The Court need only recognize that swift determination not only of the mandate's constitutionality, but of the viability of the remainder of the Act, is critical. The conclusion of the court of appeals—that the individual mandate is unconstitutional, but that the remainder of the PPACA will function as Congress intended and thus should remain standing—would have disastrous consequences for the health insurance market, and requires this Court's immediate attention. Indeed, all parties agree that the court of appeals' severability analysis was erroneous, and should be considered by this Court. American businesses need certainty now. This need for certainty will not be satisfied merely by swift review of the constitutionality of the individual mandate, although this first step is essential. The Court should also seek full briefing on a separate and equally important question presented: whether that mandate, if unconstitutional, is severable from the remainder of the Act.

REASONS FOR GRANTING THE PETITIONS

A. The Viability Of The Entire PPACA, And Not Only The Individual Mandate, Is A Question Of Overriding Importance To The Business Community, And To The Nation.

The PPACA is one of the most significant and complicated congressional enactments in decades. It "comprehensively reform[s] and regulate[s] more than one-sixth of the national economy," "via several hundred statutory provisions and thousands of regulations that put [a] myriad [of] obligations and responsibilities on individuals, employers, and the states." Appendix to the Petition for Certiorari in *Nat'l Fed'n of Indep. Bus., et al. v. Sebelius, et al*, No. 11-393 ("NFIB Pet. App.") 491a.

The PPACA's numerous provisions—and the "myriad [of] obligations and responsibilities" they impose—will have an enormous effect on American businesses. Businesses—large and small alike—will have to significantly alter their investment and hiring decisions not only to comply with the Act's requirements, but also to absorb the costs that such compliance will impose.

Continued uncertainty over the fate not only of the individual mandate, but also of all the other PPACA provisions, will seriously undermine the business community's ability to make informed decisions, thereby undermining the growth of the Nation's economy. Businesses must plan. They must plan how and when to grow. They must plan whether to create jobs or allocate capital to comply with other mandates. As long as the viability of the PPACA remains in serious question, this planning must incorporate risks of legal uncertainty that are too extensive for the average business to bear without sacrificing growth. And while risks associated with legal uncertainty always represent a significant cost, those costs—for American businesses, and the American economy—are particularly high given the breadth and complexity of the PPACA. Indeed, commentators have noted that uncertainty concerning the future of PPACA is contributing to the slow pace of the economic recovery in the United States.[3] For this reason alone, the Court should grant the petitions for certiorari and resolve whether the individual mandate is constitutional and, if it is not, to what extent the remainder of the legislation built upon the individual mandate can survive.

Moreover, the high cost of uncertainty over the PPACA's validity is not limited to the business community. Businesses are not the only entities struggling to comply with the law. Individuals and governments (including the federal government) are also currently struggling to meet the complicated and numerous new requirements of the Act. If the Court were to invalidate the individual mandate, but withhold consideration of the severability question, the processes of compliance and implementation would only become more advanced. And later decisions as to whether all or a significant part of the PPACA falls with the mandate would be all the more costly and difficult, with implementation even further under way. The longer the fate of the PPACA remains undecided, the more costly it will be to comply with whatever resolution of the severability question this Court eventually reaches.

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[3] *See, e.g.*, Dennis P. Lockhart, *Business Feedback on Today's Labor Market* (Nov. 11, 2010) (President of Federal Reserve Bank of Atlanta explaining that "a number of … factors … are impeding hiring. Prominent among these is the lack of clarity about the cost implications of the recent health care legislation. We've frequently heard strong comments to the effect of 'my company won't hire a single additional worker until we know what health insurance costs are going to be.'"), *available at* http://www.frbatlanta.org/news/speeches/lockhart_111110.cfm; Scott R. Baker et al., *Policy Uncertainty Is Choking Recovery*, Bloomberg News (Oct. 5, 2011) (explaining that uncertainty about the future of the PPACA is a major factor in slowing economic recovery), *available at* http://www.bloomberg.com/news/2011-10-06/policy-uncertainty-is-choking-recovery-baker-bloom-and-davis.html.

Finally, while the reasons in favor of considering the severability question are overwhelming, there is no compelling reason for denying review of that question. The severability issue was litigated and decided below, and all parties agree that the individual mandate's severability should be considered as a separate question presented. Moreover, denying review of the severability question now would not prevent this Court from having to review it eventually. Past experience in the lower courts demonstrates that those courts are unlikely to agree on a uniform approach to severability in the future.

Four lower courts have thus far found the mandate unconstitutional, and they have settled on four completely different severability outcomes. *See* NFIB Pet. App. 179a-194a (Eleventh Circuit opinion below) (holding the individual mandate is severable from the remainder of the PPACA); NFIB Pet. App. 365a-379a (district court opinion below) (holding the mandate is non-severable from the remainder of the PPACA); *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 790 (E.D. Va. 2010) (severing the individual mandate "and directly-dependent provisions which make specific reference to [it]" from the remainder of the PPACA); *Goudy-Bachman v. U.S. Dep't of Health and Human Servs.*, __ F. Supp. 2d __, No. 1:10-CV-763, 2011 WL 4072875, at *21 (M.D. Pa. Sept. 13, 2011) (holding the mandate non-severable from the guaranteed-issue and community-rating condition provisions, but leaving the remainder of the PPACA intact). There is no reason to believe that, in the absence of additional guidance from this Court, further percolation of the severability question would help resolve this disagreement among the lower courts on the proper application of this Court's severability principles to the PPACA. The question of severability will therefore eventually fall to this Court. Given that this Court will ultimately be forced to decide how to apply severability principles to the PPACA's complex provisions (if the mandate is held unconstitutional), there is especially little reason to decline to address the severability issue in tandem with the Court's consideration of the mandate's constitutionality.

B. The Eleventh Circuit's Severability Analysis Is Clearly Incorrect, And Will Have Disastrous Consequences For The Health Insurance Market If Left Standing.

The importance of resolving the uncertainty over which provisions of the PPACA, if any, will remain if the mandate is struck down is by itself sufficient to warrant this Court's review of the severability question. But this Court should also review that question because the Eleventh Circuit's severability decision is contrary to this Court's precedent, and will have disastrous consequences for the health insurance market if allowed to stand.

1. This Court has explained that when a court strikes down a particular statutory provision on the grounds that it exceeds Congress's constitutional powers, the remaining provisions in the act will remain standing "[u]nless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that

which is not." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (quotation marks omitted); *see also Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010). In short, the question is whether Congress would have enacted the remaining provisions in the absence of the invalid one. *See Alaska Airlines*, 480 U.S. at 685 ("The final test" for severability holds that "the unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted."). That overarching question turns on an assessment of whether the remaining provisions "will function in a *manner* consistent with the intent of Congress" in the absence of the invalidated provision. *Id.*

A proper application of these established principles demonstrates that the court of appeals erred in holding the individual mandate severable from the remainder of the PPACA. While an exhaustive survey of the proper scope of severability is unnecessary at the certiorari stage, the Eleventh Circuit's error—and the disastrous adverse consequences for the health insurance market that will result if the decision stands—is perhaps best illustrated through a brief analysis of the Act's guaranteed-issue and community-rating provisions.

The PPACA's guaranteed-issue provisions bar health insurers from denying coverage based on a subscriber's preexisting conditions or medical history. *See, e.g.*, 42 U.S.C. § 300gg-4(a) ("A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors...."). The PPACA's community-rating provisions prescribe that insurers may not charge higher premiums based on preexisting conditions and certain other factors. *See, e.g.*, 42 U.S.C. § 300gg(a)(1). Those provisions therefore preclude health insurers from increasing premiums due to any condition other than age, geography, and tobacco use. The provisions also establish limits on the extent of permissible variations in premiums based on those three factors. *Id.* § 300gg(a)(1)(A)(ii)–(iv).[4]

The United States has conceded, as it must, that the PPACA's guaranteed-issue and community-rating provisions cannot survive without the individual mandate. *See, e.g.*, Consolidated Brief for Respondents at 10 ("[T]he [Eleventh Circuit's] conclusion that the guaranteed-issue and community-rating provisions could be severed from the minimum coverage provision was incorrect.").[5] Those insurance reforms prohibit denying coverage or raising premiums based on preexisting conditions, and in the absence of the mandate, they would not "function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685.

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[4] Both the guaranteed-issue and community-rating provisions are found in Title I, Section 1201 of the PPACA. PPACA § 1201 (codified at 42 U.S.C. §§ 300gg – 300gg-7).

[5] The United States took the same position in the lower courts in this litigation. *See* Response/Reply Brief for the United States at 58, *Florida v. Dep't of Health & Human Servs.*, Nos. 11-11021, 11-11067 (11th Cir. May 18, 2011) ("[T]he guaranteed-issue and community-rating provisions ... cannot be severed from the minimum coverage requirement."); Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment at 40, *Florida v. Dep't of Health & Human Servs.*, No. 3:10-cv-91 (N.D. Fla. Nov. 23, 2010) ("As defendants have made clear ... the guaranteed-issue and community insurance industry reforms in Section 1201 will stand or fall with the minimum coverage mandate.").

Congress also fully recognized the interrelationship between those reforms and the mandate in the express terms of the Act:

> [I]f there were no [minimum coverage] requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

PPACA § 1501(a)(2)(I), 42 U.S.C. § 18091(a)(2)(I). In light of Congress's own explanation of its intent, the guaranteed-issue and community-rating provisions are plainly non-severable from the individual mandate.

As the United States has starkly explained, "'[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance.'"

Consolidated Brief for Respondents at 32 (quoting Uwe E. Reinhardt, Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce, 111th Cong. 11 (Mar. 17, 2009), *available at* http://democrats.energycommerce.house.gov/Press_111/20090317/testimony_reinhardt.pdf).[6]

Congress's concerns about an "implosion" of the health insurance markets are further reinforced by the actual experience of various states that have implemented comparable community-rating and guar-

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[6] Experts in the health care field share the view that the individual mandate is essential to the intended operation of the PPACA's guaranteed-issue and community-rating provisions. *See, e.g.*, Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the PPACA*, 364 New Eng. J. Med. 16e (Mar. 10, 2011), *available at* http://www.nejm.org/doi/full/10.1056/NEJMpv1101519?ssource=hcrc ("Although they are politically popular, these community-rating and guaranteed-issue provisions can reduce the stability of private health insurance markets.... The primary purpose of the individual mandate is to mitigate this adverse selection...."); Anthony T. Lasso, *Community Rating and Guaranteed Issue in the Individual Health Insurance Market*, National Institute for Health Care Management Foundation, at 2 (Jan. 2011), *available at* http://nihcm.org/pdf/EV-LoSassoFINAL.pdf (stressing the "distortions that can result from community rating and guaranteed issue regulations in the non-group market when there are no provisions in place to keep people enrolled in coverage"); Jonathan Gruber, *Why We Need the Individual Mandate: Without a Mandate, Health Reform Would Cover Fewer With Higher Premiums*, Center for American Progress, at 1 (Apr. 8, 2010), *available at* http://www.americanprogress.org/issues/2010/04/pdf/individual_mandate.pdf ("Without the individual mandate, the entire structure of reform would fail.").

anteed-issue provisions without an individual mandate. Seven states have enacted guaranteed-issue laws without an accompanying mandate. Ky. Rev. Stat. Ann. § 304.17A-060(2)(A) (1994) (repealed 1998); Me. Rev. Stat. tit. 24-A, § 2736-C(3); N.H. Rev. Stat. § 420-G:6; N.J. Stat. § 17B:27A-22; N.Y. Ins. L. §§ 3231, 3232; Vt. Stat. Ann. tit. 8, § 4080B(d)(1); Wash. Code § 48.43.012(1). Studies in those states reveal precisely the type of adverse selection problems that Congress sought to avoid in the PPACA. *See* Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol., Pol'y & L. 71, 97 (2000) ("Following reform, the overall percentage of the population with insurance has worsened...."); Roberta B. Meyer, *Justification for Permitting Life Insurers to Continue to Underwrite on the Basis of Genetic Information and Genetic Test Results*, 27 Suffolk U. L. Rev. 1271, 1291 (1993) (New York's community rating requirement "has led to an increase in rates for young, healthy insureds" and "many of them have dropped their health insurance coverage"). Indeed, the Kentucky market reforms were repealed because they destabilized the health insurance market. *Cf.* Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. Health Pol., Pol'y & L. 133, 151 (2000) ("The Kentucky reform experience has become notorious for the mass exit of insurers from its market.").

For those reasons, there is no basis to doubt Congress's express understanding that the individual mandate is "essential" to the proper functioning of a health insurance market that includes the PPACA's guaranteed-issue and community-rating provisions.

42 U.S.C. § 18091(a)(2)(I). The individual mandate and those reforms are a tightly interwoven group, which must stand or fall together. *Cf. Carter v. Carter Coal Co.*, 298 U.S. 238, 315-16 (1936) ("These two sets of requirements are not like a collection of bricks, some of which may be taken away without disturbing the others, but rather are like the interwoven threads constituting the warp and woof of a fabric, one set of which cannot be removed without fatal consequences to the whole.").

2. Although the PPACA severability analysis cannot end with the guaranteed-issue and community-rating provisions—and indeed, the Chamber submits that *all* the Act's insurance reform provisions are non-severable from the mandate—the severability analysis concerning those two provisions demonstrates not only the court of appeals' legal error, but also the dire consequences for both purchasers and sellers of health insurance if that error is not corrected. If, for example, the mandate falls while the guaranteed-issue and community-rating provisions remain, many will wait to purchase health insurance until they need health care services. Then—as the United States has repeatedly explained—health insurance premiums will spiral out of control, causing others to drop their existing coverage or forego the purchase of coverage.

Indeed, the turmoil in the health insurance market that would result from the Eleventh Circuit's decision is the precise consequence that Congress sought to avoid by including an individual mandate in the first place. This reality renders it all the more crucial that this Court review the Eleventh Circuit's severability analysis. This Court's review is the only meaningful avenue for avoiding the inevitable market disruption that the Eleventh Circuit's decision will produce. Accordingly, along with review of the individual mandate's constitutionality, this Court should also consider, as a separate question presented, whether the individual mandate—if unconstitutional—is severable from the remainder of the Act.

CONCLUSION

The petitions for a writ of certiorari should be granted insofar as they present the questions whether the individual mandate in the PPACA is constitutional, and if not, whether it is severable from the remainder of the Act.

Respectfully submitted,

ROBIN S. CONRAD
SHANE B. KAWKA
KATHRYN COMERFORD TODD
NATIONAL CHAMBER LITIGATION
CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

K. LEE BLALACK II
(Counsel of Record)
lblalack@omm.com
BRIAN D. BOYLE
ANTON METLITSKY
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

October 2011

AMICUS
CURIAE
BRIEF

No. 11-400

In The
Supreme Court of the United States

◆

FLORIDA, *ET AL.*,

Petitioners,

v.

DEPARTMENT OF HEALTH AND
HUMAN SERVICES, *ET AL.*,

Respondents.

◆

**On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit**

◆

BRIEF OF *AMICUS CURIAE* LAWRENCE J. DICKSON, PH.D., IN SUPPORT OF PETITIONERS

◆

DAN LAWTON
Counsel of Record
Emerald Plaza
402 West Broadway, Suite 1860
San Diego, CA 92101
(619) 595-1370
dan@lawtonlaw.com

*Counsel for Amicus Curiae
Lawrence J. Dickson, Ph.D.*

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

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INTEREST OF *AMICUS CURIAE*[1]

Dr. Dickson has greater familiarity with the effect on particular rulings on persons other than the parties than the parties themselves. Unlike them, he is an individual; a man of modest means; and the father of three young adult children, two of whom are struggling in minimum-wage (or near-minimum wage) jobs. He and most of his family have lacked medical insurance for many years. Yet they have paid their medical bills (including for hospitalizations) out of their personal savings. Their share of the government-mandated insurance premiums threatened by the Patient Protection and Affordable Care Act[2] would have both exceeded those bills and made it very hard for the family to remain solvent. Dr. Dickson's family is a class of persons who would bear a disproportionate burden of the ACA compared to other persons who have enjoyed access to good medical insurance.

Dr. Dickson also is in a position to view the case from a broader or different perspective than the parties. He is a citizen and an individual. He is a skilled mathematician who holds a doctoral degree in mathematics from Princeton University. During his career he has specialized in mathematical and scientific research. He is a holder and defender of several patents. Thus he is trained and experienced in the logic of complex documents. He has led citizen initiatives on matters of public interest in the past. He is able to capture the nature of complex problems and reduce them to their simple essence. In his brief, he combines these elements of his background to explain the demographic and financial consequences of the ACA from the perspective of an individual concerned about the inexorable results of the ACA for future generations of ordinary Americans.

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[1] The parties were notified ten days prior to the due date of this brief of the intention to file. The parties have consented to the filing of this brief.

Pursuant to Rule 37.6, Dr. Dickson hereby affirms that no counsel for any party has authored this brief in whole or in part; that no such counsel or party made a monetary contribution to fund the preparation or submission of this brief; and that no persons other than Dr. Dickson and his counsel made any such monetary contribution.

[2] Publ. L. No. 111-148, as amended by the Health Care & Educ. Reconciliation Act of 2010, Publ. L. No. 111-152 (ACA).

I

SUMMARY OF ARGUMENT

A. Background.

The Eleventh Circuit held the individual mandate provision of the ACA exceeded Congress's powers under the Commerce Clause and the Congress's Article I taxing power. It ruled the entire ACA severable from the individual mandate provision and held that the remainder of the ACA could stand. In so doing, it did not address petitioners' Fifth Amendment substantive due process challenge to the individual mandate provision (which plaintiffs asserted in the district court, but not on appeal).

In dissent, Judge Marcus noted petitioners' Fifth Amendment-based challenge to the individual mandate, which invoked Americans' "freedom from being forced to give their property to, or contract with, other private parties." *State of Florida v. Department of Health and Human Services*, 648 F.3d 1235, 1362 (11th Cir. 2011) (Marcus, J., dissenting). Judge Marcus went on to highlight the "small class of fundamental rights" protected today under the Fifth Amendment's guarantee of substantive due process, *i.e.*, the rights to marry, have children, and direct the education and upbringing of children, among others. *Id.* Judge Marcus rejected the notion that the individual liberty interest asserted by petitioners was a fundamental right. But neither he nor the majority discussed whether the individual mandate might violate any individual American's fundamental rights to have children and/or direct their education and upbringing.

B. Whether the Individual Mandate Provision of the ACA Violates Young Americans' Right to Substantive Due Process Guaranteed by the Fifth Amendment Is an Important Question of Federal Law Which Has Not Been, but which Should Be, Settled by This Court.

This case raises the issue of whether the individual mandate of the ACA violates the Fifth Amendment guarantee of substantive due process. The individual mandate burdens the rights to marry and raise children. These rights are fundamental. The burden falls most heavily on the young and presently uninsured. This burden cannot and should not stand. This Court should grant *certiorari* to address this important issue.

II
ARGUMENT

A. The False and Iniquitous Logic Of The Individual Mandate.

The individual mandate is supposedly a tool aimed at containing costs while simultaneously providing universal coverage and eliminating insurers' refusals to cover patients with preexisting conditions. The proffered logic posits a scenario in which healthy people forgo insurance until they are sick and purchase insurance just at the moment when the insurer will have to spend most on their care, thus assertedly triggering insurers' shifting of the costs to those they already insure. This, in turn, boosts premiums, discouraging healthy persons from purchasing insurance, and, in the end, leaving only the truly sick in the insurance pool. This is the so-called "death spiral." Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health, 111th Cong. (Mar. 17, 2009) (testimony of Princeton University Professor Uwe Reinhardt). The individual mandate and universal coverage required by the ACA supposedly eliminate the "death spiral."

This logic is false and iniquitous.

It disparately treats two types of persons. The first person may satisfy the individual mandate from the first day, yet always draw more from the pool than he pays into it. The second, perhaps poorer, never draws much and suffers a net loss from having to pay premiums without receiving care of equivalent value. The individual mandate forces the second person to carry the first.

The idea that, when patients need care, they will have been paying into the system, is wrong in two ways. First, it unjustifiably assumes that everyone is predictably sickly to the same degree. Thus it cloaks the injustice to people who are healthy but poor, and would more wisely decide not to buy. Second, and more subtly, it treats the dollar of payment at one time as equivalent to the dollar of care perhaps much later. This ignores the harm that may befall the patient (unrelated to health care) because of the absence of that dollar to meet other needs at the earlier date.

As explained below, these harms burden young Americans' rights to marry and raise children.

B. Disproportionate Financial Burden on Young Americans.

The Due Process Clause of the Fifth Amendment guarantees that no person shall be deprived of life, liberty, or property, without due process of law. Its substantive component is implicated in this case. Substantive due process protects a small class of fundamental rights. Among these are the rights to marry, have children, and direct the education and upbringing of one's children. *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

The ACA appears to violate these rights, by burdening their exercise with financial consequences not now extant.

The group most unfairly burdened by the individual mandate is the young. The young are as much as seven times healthier than the elderly. Unregulated insurance rates demonstrate this.[3] The mean personal income of the young (aged 15-34), however, is only half that of their elders (aged 35-64). Given unavoidable basic needs, this means the discretionary income of the young is much less than half that of their elders. This means the individual mandate they must pay under the ACA will fall on the young twice as heavily as on the old, on average. This cannot comport with fairness.

The ACA's disproportionate burden on the young is made clear by the premium age ratio limit of 3 to 1 (ACA, § 2701(a)(1)(A)(iii)). The young stand to pay a surcharge which will benefit not them but another, favored group:

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[3] Carla K. Johnson, "Health premiums could rise 17% for young adults" (March 29, 2010) <http://news.yahoo.com/s/ap/20100330/ap_on_he_me/us_health_care_age_matters>

> Insurers typically charge six or seven times as much to older customers as to younger ones in states with no restrictions. The new law limits the ratio to 3-to-1, meaning a 50-year-old could be charged only three times as much as a 20-year-old.

See Johnson, *supra*.

Johnson predicts a 17% overcharge, and Chuck Bassett 35%.[4] These estimates underestimate the injustice, however. If the real costs of old are seven times those of young, and the new law limits premiums to three times those of the young, then a simple calculation, based on the idea that young and old generations are about the same size, yields this table:

	Young	Old	Total
Costs	1	7	8
Premiums	2	6	8

Therefore, under these assumptions, young people's premiums will be double what is fair, and 50% of what is forced out of relatively low-paid young people by compulsory insurance will go to subsidize the relatively wealthy older generation.

Even if we optimistically assume the younger generation is twice the size of the older generation (which is unrealistic in this age of falling birthrates), the assumption still yields higher costs for young than for old:

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[4] Chuck Bassett, "Health Care Reform Overview" (May 6, 2010) <http://afterthevote.com/wpcontent/uploads/2010/04/HC-Reform-Overview-BCBS-and-MSEC-May-2010.pdf.>

	Young	Young	Old	Total
Costs	1	1	7	9
Premiums	1.8	1.8	5.4	9

So, under the unrealistically optimistic assumption, **young people are still subjected to a compulsory 80% overcharge, and 44% of their payments will go to subsidize the older generation.**[5]

Backing the elder costs to six times those of the young (which is not consistent with the recent behavior of health costs, which always push the envelope especially for near-death care) yields a 60% to 75% overcharge according to the same two calculations. This is a heavy burden.

C. Likelihood Of Runaway Costs.

United States health care costs are rising fast. They have gone from 16.2% of GDP in 2007[6] to 17.6%

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[5] The mathematical formula is: (number of young) x (cost per young) + (number of old) x (cost per old) = (number of young) x (young premium) + (number of old) x 3 x (young premium).

This remains valid if the intermediate age group pays equally to their cost.

[6] John C. Medaille, Toward a Truly Free Market: A Distributist Perspective on the Role of Government, Taxes, Health Care, Deficits, and More 207 (ISI Books 2010).

of GDP in 2009 (well above projections of 17.3%).[7] This is about double the percent of a country that is comparable in technological advancement and age distribution (Britain, 8.4% in 2006).[8] The cause of this disparity is simple economics: two major instances of monopoly, drug patents and the AMA restriction on qualified medical practitioners. According to John Medaille:[9]

> The market normally will provide the proper signals to producers telling them how much product to supply to the market and at what price. But monopoly destroys this mechanism; the monopolist may demand a share of whatever funds are supplied to a given market, and the more funds supplied, the higher the prices go without increasing the supply of the product. This is sufficient to explain why medical expenses consume an ever increasing share of the GDP without increasing the number of people covered. More funding means only higher prices, not more actual goods supplied.

The GDP percentage figures quoted above have actually been restrained by the increasing proportion of Americans going uninsured and avoiding medical care. The ACA does little to increase supply of medical goods, and nothing to alleviate the legal monopolies. It forces a large increase in the number of people covered. It forces the use of insurance, which adds agency costs, and introduces an indirect method of payment which reduces the effectiveness of the price mechanism. It is therefore predictable that the price surge, already visible as a percentage of GDP, will continue and grow worse. Though payment of a $400 tax or fine is an alternative to the insurance requirement as the ACA is now written, the $400 sum is akin to the "camel's nose"; Congress could significantly boost this amount in future years, imposing an even heavier burden on taxpayers.

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[7] Department of Health and Human Services, "National Health Expenditure Data NHE Fact Sheet" (June 14, 2011), <https://www.cms.gov.NationalHealthExpendData/25_NHE_Fact_sheet.asp.>

[8] Medaille at 207.

[9] *Id.* at 212.

The result is a predictable and almost immediate funding shortfall, which cannot be leveraged away due to the well-known debt problems of the Federal Government. Thus it can be no defense of the individual mandate that the ACA offers rate limits and subsidies for the poorest, *e.g.*, ACA § 36B(b)(2). This is because, once the individual mandate is permitted, such details are subject to legislative change, and rates may rapidly be raised to or beyond the point of diminishing returns when Congress seeks money for deficit-cutting in the future – as it seemingly inevitably will.

D. Irreparable Impact of These Costs on Marriage and Child-Rearing of Young Americans.

The bad stewardship required by the ACA is compounded by the lack of a market mechanism to relieve the pressure. The move of people off medical insurance, and the lesser use of medical care, that have taken place since 2008 due to recession and high unemployment, were a market response that relieved the pressure. But this "safety valve" will become illegal in 2014, unless this Court acts to invalidate the individual mandate provision of the ACA.

Unemployment exacerbates the harm to the young threatened by the ACA. This is because unemployment is much higher among the young than among their elders.[10] A change that will worsen unemployment, especially unemployment in starting jobs, is therefore a disproportionate blow to the young. Most new employment is by small businesses. A heavy regulatory environment, such as is imposed by the two-thousand-page ACA, disproportionately affects small business. The surge in costs due to cutting off the "safety valve" will make accurate planning difficult, if not impossible.

Predictably, many small business owners will choose to work longer hours themselves rather than hire – thus worsening the ACA's burden on young Americans.

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[10] Zachary Roth, "Reluctant slackers: economy leads young Americans to put adulthood on hold," *The Lookout* (October 6, 2011) <http://news.yahoo.com/blogs/lookout/reluctant-slackers-economy-leads-young-americans-put-adulthood-202742832.html>

Once youth unemployment has risen, there is no automatic tendency for an economic cycle to bring it down. As Egypt, Tunisia, Jamaica, Spain and many other countries have shown, it can remain at elevated rates, 20% to 40% or more, for years[11] and decades, reaching a neutrally stable state in which some actively participate in the economy while the rest are left behind.

The cumulative and foreseeable result of these economic probabilities is that the discrimination designed into the ACA will irreparably harm unfavored citizens. Those who do earn will suffer rapidly escalating compulsory insurance costs, just as they should be gaining the surplus that normally allows them to form families. How deeply this can cut is shown already by marriage rates, currently plummeting in the United States for economic reasons.[12] Forming families is the natural activity and joy of the young. It cannot be made good by a boon at age sixty. Missing it in youth means missing it forever.

The ACA places American young people in a vulnerable position. "Even three full-time minimum wage jobs doesn't make enough to make ends meet

---

[11] "Young, jobless, and looking for trouble," *The Economist* (February 3, 2011) <www.economist.com/blogs/schumpeter/2011/02/youth_unemployment>

[12] Roth, *supra*.

[for a family of three] in San Diego County." But "[i]n the last three years . . . health care costs went up 27 percent . . . according to the report."[13] It is fair to conclude from the foregoing data that bypassing health care costs can bring normal family life within reach of many. But the ACA's individual mandate will forbid that choice. Like buoyancy to a swimmer, the surplus destined for taking by the ACA's individual mandate is critical to many young families.

The young couple, kept unemployed or prevented from accumulating a surplus by the heavy oppression of the individual mandate, who cannot found a family because of that – and hundreds of thousands or millions of young Americans will predictably be in this marginal class – is denied the chance to contribute to our country their children, our country's future.

The ACA's individual mandate will burden a disfavored class of United States citizens (the healthy but impecunious young) for no other purpose than to make a system work for favored classes – the elder generation, and the medical industries. The disfavored citizens are treated as unequals and instruments. The ACA, once effective, will force them to haul an unduly heavy burden. For many of them this will foreseeably damage their chances at one of the fundamental rights protected by the Fifth Amendment – the right to marry and raise a family.

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[13] City News Service, "Study: cost of self-sufficiency for family of three in San Diego up $10K in 3 years" (October 4, 2011) <http://www.cbs8.com/story/15615498/study-cost-of-self-sufficiency-for-family-of-three-in-san-diego-up-10K-in-3-years>

This Court should decide the important question of whether such damage runs afoul of the substantive due process guaranteed by the Fifth Amendment.

◆

CONCLUSION

Dr. Dickson asks that this Court grant him leave to file this brief and that it grant the petitions for *certiorari* now pending.

Respectfully submitted,

Dated: October 31, 2011
DAN LAWTON

AMICUS CURIAE BRIEF

Nos. 11-393 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, et al.,
Petitioners,
v.
KATHLEEN SEBELIUS, Secretary of Health and Human Services, et al.,
Respondents.

STATE OF FLORIDA, et al.,
Petitioners,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Respondents.

On Petitions for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF THE FAMILY RESEARCH COUNCIL AND 30 MEMBERS OF THE U.S. HOUSE OF REPRESENTATIVES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

KENNETH A. KLUKOWSKI
FAMILY RESEARCH COUNCIL
801 G Street N.W.
Washington, D.C. 20001
(202) 637-4617

NELSON LUND
Counsel of Record
GEORGE MASON UNIVERSITY SCHOOL OF LAW
3301 Fairfax Drive
Arlington, Virginia 22201
(703) 993-8045
nlund@gmu.edu

October 27, 2011

Attorneys for Amici Curiae

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTION PRESENTED

Whether certiorari should be granted on the severability issues that will be presented if any provisions of the Patient Protection and Affordable Care Act are held unconstitutional.

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INTEREST OF *AMICI CURIAE*[1]

The Family Research Council ("FRC") is a 501(c)3 nonprofit public-policy organization headquartered in Washington, D.C., that exists to develop and analyze governmental policies that affect families in the United States. Founded in 1983, FRC advocates policy enactments that protect and strengthen family rights and autonomy, and assists in legal challenges of governmental actions detrimental to family interests.

Various provisions of the Patient Protection and Affordable Care Act are contrary to family interests. These provisions—and regulations enacted pursuant thereto—impair family autonomy regarding health care choices, coerce individual decisionmaking, fund abortions, and make health care less affordable for families. These interests are central to FRC's mission, and will be fully vindicated only by holding the Act unconstitutional in its entirety.

Remaining *amici curiae* are 30 Members of the House of Representatives in the United States Congress seeking complete invalidation of the Act, each of whom represents constituents whose interests are implicated by the issues presented in this case. Those Members are listed alphabetically in the Appendix to this brief.

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[1] Nelson Lund and Kenneth A. Klukowski authored this brief for *amici curiae*. No counsel for any party authored this brief in whole or in part and no one apart from *amici curiae* made a monetary contribution to the preparation or submission of this brief. Counsel of record for all parties received notice at least 10 days prior to the due date of the *amici curiae's* intention to file this brief.

REASONS FOR GRANTING THE PETITIONS

I. THE COURT BELOW MISAPPLIED THE LAW OF SEVERABILITY.

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [collectively, "ACA" or "the Act"] contains one or more unconstitutional provisions, as the court below recognized. Faced with a statute that is unconstitutional in part, courts must decide which of the statute's remaining provisions, if any, may be given effect. Beginning with its earliest cases, this Court has consistently regarded the resolution of this question as a matter of faithfully effectuating the legislature's intent. *See, e.g.*, Robert L. Stern, *Separability and Separability Clauses in the Supreme Court*, 51 Harv. L. Rev. 76, 106 (1937).

At one time it was common for the Court to find that unconstitutional provisions were nonseverable. *Id.* at 107-09 (collecting cases). Beginning around the turn of the twentieth century, legislatures began including clauses specifying that invalid provisions should be treated as severable. *Id.* at 115. Although such clauses do not resolve all severability questions, this Court has in recent decades encountered relatively fewer cases in which unconstitutional provisions have been found to be nonseverable. *See, e.g.*, John C. Nagle, *Severability*, 72 N.C. L. Rev. 203, 220-21 (1993); *see also Schiavo ex rel. Schindler v. Schiavo*, 404 F.3d 1270, 1275 (11th Cir. 2005) (Birch, J., specially concurring) ("In most cases where unconstitutional sections of a statute have been severed the legislation has contained a severability clause.").

The leading modern case, *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987), reviewed the precedents and provided a detailed summary of the law. The key principle is that the "relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress. . . . The final test . . . is the traditional one: the unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted." *Id.* at 685 (footnote omitted).

As the Court has acknowledged, this inquiry can be "elusive." *INS v. Chadha*, 462 U.S. 919, 932 (1983). It is "eased" when the statute includes a severability clause because such a clause creates a presumption that Congress did not intend the validity of the statute as a whole to depend on the validity of an unconstitutional provision. *Alaska Airlines*, 480 U.S. at 686.[2] The presumption created by a severability clause obviously cannot exist in a case involving a statute without a severability clause, like the ACA.[3] In the absence of such a clause, courts must recur to the standard techniques for ascertaining the intent of

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[2] This presumption can be overcome, as in cases where "the balance of the legislation is incapable of functioning independently" and would have to be judicially rewritten in order to operate at all. *Alaska Airlines*, 480 U.S. at 684 (citation omitted).

[3] The Court has also noted that "[i]n the absence of a severability clause, however, Congress' silence is just that—silence—and does not raise a presumption against severability." *Alaska Airlines*, 480 U.S. at 686 (citations omitted).

Congress: by looking "in the language and structure of the [statute] and in its legislative history." *Id*. at 687.

This Court recently observed that when confronting a statute with a constitutional flaw, "we try to limit the solution to the problem," and the Court seeks to avoid rewriting the statute or unnecessarily invalidating the statute as a whole. *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328-29 (2006)). Accordingly, "the normal rule is that partial, rather than facial, invalidation is the required course." *Id*. (citation and internal quotation marks omitted).

It remains the law, however, that the Court must not sustain a statute's otherwise valid provisions when "it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid]." *Id*. (quoting *Alaska Airlines*) (internal quotation marks omitted). Accordingly, the Court has reaffirmed that severability is "essentially an inquiry into legislative intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). Applying that principle to an Executive Order, for example, the Court concluded that the President intended the Order to stand or fall as a whole. *Id*. at 191-95. Similarly, the Court has refused to sever invalid campaign contribution limits from others that might remain fully operative because it was unable to "foresee which of many different possible ways the legislature might respond to the constitutional objections we have found." *Randall v. Sorrell*, 548 U.S. 230, 262 (2006) (plurality opinion).

The fundamental principle reaffirmed in *Alaska Airlines*—effectuating congressional intent—thus remains in place. Many federal statutes create a presumption of severability by including a severability clause in their texts. With statutes like the ACA, however, indicia of congressional intent must be found elsewhere—in the structure of the text, in the legislative history, and in the nature of the relationship among the effects the legislature intended various provisions to have. That inquiry must be conducted on a case-by-cases basis, and there is no independent or background presumption of severability in the law recognized and consistently adhered to by this Court.

A. The court below misinterpreted this Court's precedents.

The court below misinterpreted this Court's precedents, apparently reading them to create a virtually insurmountable presumption in favor of severability, even in the absence of a severability clause.[4] By discounting or ignoring numerous indicators that Congress would not have enacted the remainder of the statute without the so-called individual mandate in Section 1501 of the Act, the

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[4] In its enthusiastic search for support of this misinterpretation, the court below went so far as to cite *United States v. Morrison*, 529 U.S. 598 (2000). *See* NFIB Pet. App. 181a. In that case, the parties did not raise any issue about severability and the Court performed no severability analysis. Severability was not at issue in the case, and the Court's decision can lend no support to the Eleventh Circuit's search for authorities to support its misguided analysis.

Eleventh Circuit misapplied the law and frustrated the intent of Congress.

As the court below acknowledged, there is evidence that Congress did not intend invalid provisions to be severable. First, the version of this statute that initially passed the House of Representatives included a severability clause. *See* H.R. 3962, 111th Cong. § 255 (2009) (as passed by House, Nov. 7, 2009). After receiving and considering this bill, the Senate substituted a revised bill that did *not* include such a clause, and that bill was eventually enacted. *See* H.R. 3590, 111th Cong. (2009) (as passed by Senate, Dec. 24, 2009). This can only be regarded as a deliberate choice by Congress to reject the inclusion of a severability clause, and this choice implies that Congress did not intend to create a presumption of severability.

The court below, however, dismissed this legislative history on the authority of congressional drafting manuals, which counsel that a severability clause is unnecessary except when the drafter wants to guarantee that a provision will be held *nonseverable*. NFIB Pet. App. 183a-184a. That a severability clause may often prove to be unnecessary, however, does not imply that such clauses are *meaningless* or that they are mere superfluities. And the congressional drafting manuals certainly do not say or imply that the deliberate *removal* of a severability clause during the legislative process cannot be evidence of congressional intent. The court below nonetheless concluded that the removal of the severability clause during the legislative process in this case "has no probative impact on the severability question before us." *Id.* at 184a. This conclusion was error.

The court below also discounted other indications from Congress that it would not have enacted the remainder of the ACA without the individual mandate provision. First, as the court recognized, the statute itself specifically says that the individual mandate "is *essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold." *Id.* (quoting ACA § 1501(a)(2)(I), to be codified at 42 U.S.C. § 18091(a)(2)(I)) (emphasis added). This provision of the statute alone is sufficient to confirm, at a minimum, that Congress did not intend for the guaranteed issue and other preexisting conditions provisions in Section 1201 of the statute to take effect without the individual mandate.[5]

Compounding its mistaken reading of the congressional drafting manuals, however, the court below refused to credit what Congress actually said in the text of the ACA. Instead, the court misinterpreted the congressional drafting manuals to imply that if that is what Congress really meant it should have inserted an expressly worded *nonseverability* clause. *See* NFIB Pet. App. 183a- 184a. This Court has never so much as suggested that Congress is required to express its intent in the way that the court below demanded, or that Congress must comply with the

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[5] What the court of appeals referred to as the provision securing "coverage of pre-existing conditions" is sometimes referred to as the "community-rating" provision. The guaranteed-issue provision ensures that individuals with preexisting conditions cannot be denied coverage, while the community-rating provision ensures that such individuals cannot be charged higher (or lower) insurance premium payments due to individual health factors.

Eleventh Circuit's mistaken inferences from congressional drafting manuals. Once again, the reasoning of the court below is untenable.

The court below also argued at length that removing the individual mandate would have only limited effects on the operation of the statute. *Id.* at 188a–193a. The Eleventh Circuit may not think that the individual mandate is "essential" to the operation of other provisions of the ACA, but Congress thought differently *and said so in the statute*. Under this Court's severability decisions, Congress' view is dispositive and is not to be second-guessed by the courts.

In *Free Enterprise*, this Court accepted *Alaska Airlines*' focus on congressional intent and found that "*nothing* in the statute's text or historical context makes it 'evident' that Congress, faced with the limitations imposed by the Constitution, would have preferred no Board at all to a Board whose members are removable at will." 130 S. Ct. at 3162 (emphasis added) (citations to *Alaska Airlines* and *Ayotte* omitted). The *Free Enterprise* Court obviously looked at the text and historical context and found *nothing* to suggest that the unconstitutional removal provision was intended to be nonseverable. What this Court did *not* do was look in those sources and reject multiple indicia of congressional intent as insufficient to overcome a judicially created presumption of severability. And for good reason: No such presumption exists. Neither *Free Enterprise* nor any other decision of this Court licensed the court below to systematically discount or reject evidence of congressional intent in the text of the statute and in its legislative history.

B. The court below misapplied the law in considering partial severability.

The court below was "not persuaded that it is *evident* (as opposed to possible or reasonable) that Congress would not have enacted the [guaranteed issue and preexisting conditions] reforms in the absence of the individual mandate." NFIB Pet. App. 193a. This Court's cases have used the word "evident," but certainly not in the sense of "proven beyond any doubt." The reason the court below was not persuaded was that it refused to credit the kind of evidence that this Court has insisted must be credited. Even the Solicitor General has recognized that the Eleventh Circuit's conclusion is untenable. *See id.* at 194a n.144.

Even assuming, *arguendo*, that Congress might have intended some provisions of the ACA to go into effect without the statute's invalid provisions, the petitions should be granted so that the Court can consider whether certain other provisions cannot be severed from those that are unconstitutional. Even under its flawed approach, the Eleventh Circuit acknowledged that it is a much closer question whether the individual mandate provision can be severed from the provisions dealing with guaranteed issue and preexisting conditions. *Id.* at 184a.

Section 1501 of the Act includes a congressional finding that without the individual mandate, persons taking strategic advantage of the guaranteed-issue and preexisting conditions provisions of the ACA would render Section 1201 of the Act unworkable because of adverse selection problems. The consequences of this adverse selection would seriously (and perhaps fatally) undermine what Congress regarded as a desirable reform of the health care insurance market.[6] The Solicitor General conceded at oral argument in the court below that the guaranteed-issue and community-rating provisions must stand or fall with the individual mandate, yet the Eleventh Circuit expressly rejected the agreement of *all parties* on this point. *See id.* at 194a n.144.

This Court should grant certiorari to consider whether this extraordinary rejection of the Government's own concession, as well as the lower court's refusal to credit the evidence supporting the Government's concession, may stand.

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[6] The relevant provision of the Act provides:

> Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no [individual-mandate] requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

ACA § 10106 (amending § 1501(a)(2)(I)), 124 Stat. 908.

II. THE LOWER COURTS HAVE STRUGGLED TO APPLY THIS COURT'S SEVERABILITY JURISPRUDENCE TO THE ACA.

An additional reason to grant the writs is that the lower courts are struggling to apply this Court's severability doctrine. Several cases challenging the ACA illustrate this point.

As seen in this case, the district court and the court of appeals took diametrically opposed positions. The district court concluded that the entire statute must fall, *id.* at 378a–379a, while the Eleventh Circuit concluded that only the individual mandate need be invalidated, *id.* at 184a, 194a.

In the Fourth Circuit, the Eastern District of Virginia invalidated the individual mandate, and then held that the invalid provision was completely severable from the remainder of the Act. The court's discussion of severability, however, was very brief, and evinced an understanding of the applicable doctrine that was quite different from either of the courts in the Eleventh Circuit. *See Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 789–90 (E.D. Va. 2010), *vacated on jurisdictional grounds*, 2011 U.S. App. LEXIS 18632 (4th Cir. Sept. 8, 2011), *petition for cert. filed*, No. 11-420 (U.S. Sept. 30, 2011).

Recently, the Middle District of Pennsylvania concluded that its invalidation of the individual mandate provision required that it also strike the guaranteed-issue and preexisting conditions provisions in ACA § 1201, but not the entire statute. *Goudy-Bachman v. U.S. Dep't of Health and Human Servs.*, 2011 U.S. Dist. LEXIS 102897, at *69–70 (M.D. Pa. Sept. 13, 2011).

Thus far four federal courts—one circuit court and three district courts—have invalidated Section 1501 and thus had occasion to consider severability. Those four courts have now split three ways on how this Court's established doctrine applies to this statute. This confusion among the lower courts reinforces the importance of granting certiorari on the severability issues.

III. IF THIS COURT FINDS ANY PROVISION OF THE ACA UNCONSTITUTIONAL, IT SHOULD SIMULTANEOUSLY RESOLVE THE SEVERABILITY ISSUE.

If this Court invalidates any of the challenged provisions in this litigation, it should also resolve the question of severability.

Depending on the format, the statute at issue is either 975 pages or approximately 2,700 pages long. *See* NFIB Pet. App. at 179a, 376a. The provisions challenged in this litigation are part of a complex and delicately balanced restructuring of a large sector of the Nation's economy. *See id.* at 380a–381a. The statute includes mandates and programs dealing with such interrelated matters as requiring individuals to buy specified insurance products, requiring employers to provide health care plans and certain health-related accommodations, requiring insurers to provide certain policy benefits, and requiring States to expand a massive grant-in-aid program and to create insurance exchanges. Many of the statute's provisions further authorize Executive Branch officers to promulgate regulations with additional complex and interrelated effects on the public and private sectors of the economy.

Uncertainty about which, if any, of the ACA's provisions will prove to be enforceable has a deleterious effect not only on State governments and the private health care sector, but on the Nation's economy as a whole. *See, e.g.*, Paul Howard, The Impact of the Affordable Care Act on the Economy, Employers, and the Workforce (Feb. 9, 2011), *available at* http://www.manhattan-institute.org/pdf/testimony_02092011PH.pdf (last visited Oct. 21, 2011).

Should this Court invalidate any of the challenged provisions of the ACA, it would be counterproductive to await an additional round of briefing on the severability issue, let alone to remand that issue to the lower courts, where confusion has already emerged. The national interest strongly counsels in favor of resolving this issue along with the constitutional issues.

The Court should therefore grant certiorari on the question of severability along with other issues presented in this case.

CONCLUSION

The Court should grant both of the petitions that raise severability issues, Nos. 11-393, 11-400. For the reasons given in the petitions and in this *amicus* brief, those issues are certworthy and of considerable and immediate practical significance.

Respectfully submitted,

NELSON LUND
Counsel of Record
GEORGE MASON UNIVERSITY
SCHOOL OF LAW
3301 Fairfax Drive
Arlington, Virginia 22201
(703) 993-8045
nlund@gmu.edu

KENNETH A. KLUKOWSKI
FAMILY RESEARCH COUNCIL
801 G Street N.W.
Washington, D.C. 20001
(202) 637-4617
kklukowski@frc.org

Attorneys for Amici Curiae

October 27, 2011

APPENDIX

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Appendix A: List of *Amici Curiae* 1a

APPENDIX A

A total of 30 Members of the House of Representatives in the United States Congress have joined this brief as *amici curiae*. These Members of Congress are:

Rep. Roscoe Bartlett of Maryland, 6th district

Rep. Joe Barton of Texas, 6th district

Rep. Diane Black of Tennessee, 6th district

Rep. Marsha Blackburn of Tennessee, 7th district

Rep. Charles Boustany, M.D., of Louisiana, 7th district

Rep. Dan Burton of Indiana, 5th district

Rep. Steve Chabot of Ohio, 1st district

Rep. Tom Cole of Oklahoma, 4th district

Rep. Blake Farenthold of Texas, 27th district

Rep. Mike Fitzpatrick of Pennsylvania, 8th district

Rep. Jeff Fortenberry of Nebraska, 1st district

Rep. Louie Gohmert (former Judge) of Texas, 1st district

Rep. Tom Graves of Georgia, 9th district

Rep. Andy Harris, M.D., of Maryland, 1st district

Rep. Duncan Hunter of California, 52nd district

Rep. Steve King of Iowa, 5th district

Rep. Raul Labrador of Idaho, 1st district

Rep. Doug Lamborn of Colorado, 5th district

Rep. Jeff Landry of Louisiana, 3rd district

Rep. James Lankford of Oklahoma, 5th district

Rep. Dan Lungren of California, 3rd district

Rep. Randy Neugebauer of Texas, 19th district

Rep. Steve Pearce of New Mexico, 2nd district

Rep. Mike Pompeo of Kansas, 4th district

Rep. Tom Price, M.D., of Georgia, 6th district

Rep. Reid Ribble of Wisconsin, 8th district

Rep. Steve Scalise of Louisiana, 1st district

Rep. Jean Schmidt of Ohio, 2nd district

Rep. Lamar Smith of Texas, 21st district, Chairman, House Committee on the Judiciary

Rep. Joe Walsh of Illinois, 8th district

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

In The
Supreme Court of the United States

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NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, et al.,

Petitioners,

v.

KATHLEEN SEBELIUS,
Secretary of Health & Human Services, et al.,

Respondents.

◆

FLORIDA, et al.,

Petitioners,

v.

DEPARTMENT OF HEALTH
AND HUMAN SERVICES, et al.,

Respondents.

◆

**On Writs Of Certiorari To The
United States Court Of Appeals
For The Eleventh Circuit**

◆

BRIEF OF AMICUS CURIAE FREEDOM WATCH IN SUPPORT OF NEITHER PARTY AND ON ISSUE OF RECUSAL OR DISQUALIFICATION OF JUSTICE ELENA KAGAN

◆

LARRY KLAYMAN, ESQ.
Chairman and General Counsel
FREEDOM WATCH
2020 Pennsylvania Ave., N.W., Suite 345
Washington, D.C. 20006
leklayman@yahoo.com
(310) 595-0800

Counsel for Amicus Curiae

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964

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INTEREST OF THE AMICUS CURIAE

Freedom Watch is a public interest group dedicated to preserving freedom, pursuing individual rights and civil liberties, while fighting for ethics in government and the judicial system. As part of its goal to remain constant to the principles of the Founding Fathers, Freedom Watch is dedicated to ensuring the rights of all citizens through action, frequently with legal cases and other means. With the passage of the Patient Protection and Affordable Care Act of 2010 (the Act), the federal government ("government") is seeking to intrude into citizens' rights, regulating private and intimate aspects of an individual's life without regard to the Constitution. In doing so, the government is expanding the scope of its limited and enumerated powers to a level never before seen. With the majority of the citizens opposed to the Act, and many concerned with the size and power of the government, Freedom Watch is required to speak on behalf of those unable to do so. As such, consistent with its mission, Freedom Watch seeks to provide the means and mechanism to protect American citizens' rights in this matter of great public interest.[1]

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[1] Written consents from both parties to the filing of amicus curiae briefs in support of either party are on file with the Clerk. No person or entity other than amicus curiae or its counsel made a monetary contribution to preparation or submission of this brief.

SUMMARY OF ARGUMENT

This brief seeks to request the recusal and, if necessary, disqualification of Justice Elena Kagan in the decision of the constitutionality of the Patient Protection and Affordable Care Act of 2010 (the Act). Justice Kagan served in her former role as Solicitor General of the United States, whereby she participated in crafting a defense for the constitutionality of the Act. She therefore acted as counsel to the drafters in developing a strategy to defend the law. This role should disqualify Justice Kagan under 28 U.S.C. §455(a) because her "impartiality might reasonably be questioned." Unlike allegations of partiality concerning Justice Clarence Thomas, Justice Kagan's involvement is not a matter of another member of her family playing a partisan role concerning the Act. Her past involvement is personal and direct. The case to recuse or disqualify Justice Kagan is thus much stronger.

Furthermore, statements made by Justice Kagan in a series of released emails clearly demonstrate Justice Kagan's encouragement and delight at the passage of the Act. These statements, at the very least, demonstrate Justice Kagan's personal bias in favor of the Act. Personal bias is grounds for disqualification under 28 U.S.C. §455(b)(1). In addition, her involvement in crafting a defense disqualifies her since she served as "counsel, advisor, or material witness concerning the proceeding" under 28 U.S.C. §455(b)(3). Finally, the Due Process Clause of the Fifth Amendment also mandates that in cases with extreme fact patterns such as this one the probability of actual bias rises to an unconstitutional level, requiring Justice Kagan's recusal and/or disqualification.

Recent comments by Chief Justice John Roberts in his Annual Report on the State of the Federal Judiciary, which seek to defend Justice Kagan and clearly state that she should not recuse herself, are an affront the judicial system and the American people, who depend on judges to be neutral, unbiased and independent. They underscore why the nation has lost trust in government, and why movements like the Tea Party and Occupy Wall Street have sprung up from all ends of the political spectrum. Simply put, "We the People" are fed up and have already entered into what is in effect a Second American Revolution because judges and other government officials behave as if they are "above the law," in effect nobility who can do as they please. This amicus brief, which addresses the recusal or disqualification of Justice Kagan, is even more important to preserving the ethical foundations of our Republic than the underlying issues of the constitutionality of the Act. Without a neutral, unbiased Supreme Court, there simply is no rule of law and any decision concerning the Act will be seen as illegitimate.

Regrettably, and outrageously, before even considering these recusal and disqualification issues, Chief Justice Roberts prejudged these serious issues and stated in his annual report that Supreme Court justices need not follow the recusal and disqualification ethics rules that pertain to other federal judges and that these ethics rules may be unconstitutional. Incredibly, and to add insult to injury, he added that "(t)he Supreme Court does not sit in judgment of one of its own members. . . ." This admission, among others in the report, says it all and ironically underscores why recusal or disqualification of Justice Kagan is necessary to preserve the integrity of the Supreme Court for the citizens of the United States. The Court does not belong to either Chief Justice Roberts or any other justice; it belongs to "We the People." And, if the justices cannot adhere to the rule of law, which includes judicial ethics, then the Court must be stripped clean of this lawlessness by removing and prosecuting, through whatever legal means are available, those justices who refuse and fail to play by the same rules that they hold citizens and others accountable for.

In short, the comments of Chief Justice Roberts are an affront to the high ethical standards of our Founding Fathers and amount to a subversion of our laws. They are disgraceful at best and at worst amount to obstruction of justice. They are the result of someone who became Chief Justice by first ingratiating himself to the "Washington establishment," and now seeks to act as the Chief Justice not just of the Court, but of this same establishment – which for decades has pushed the nation to the brink of revolution by representing mostly its own interests, perpetuating and consolidating its power and selling out

"We the People." This is why in large part the nation is in a deep crisis; the majority of Americans have little if any respect for either the Supreme Court or our judiciary as a whole, notwithstanding their current similar disdain for the other two branches of government.

The situation is as bad as in 1776 when "We the People" declared independence from King George III and the British Crown. In the 236 years since the start of the first American Revolution, our current ruling class, which is not of the mettle of our Founding Fathers, – who pledged their sacred honor, fortunes and risked their lives to create a free nation – has come full circle. Today, the Supreme Court and the other two branches of government have assumed the role of a "royalty" – in some ways worse than even King George III – who feel free to ignore the legitimate interests and grievances of "We the People," because they believe they are a "protected class" and above the law.

The issue of recusal and disqualification is of paramount importance to this case. The Supreme Court, the highest court of the land, must maintain a level of integrity that is beyond reproach. If Justice Kagan refuses to recuse herself in this matter, Freedom Watch demands on behalf of the American people that this Court disqualify her from the proceedings. The Supreme Court is the only court that has no mechanism or governing body to enforce ethics violations, and it is thus up to the justices themselves to ensure that there is not even the slightest hint or appearance of partiality. If these justices will not police themselves, they have lost all ethical and legal authority to sit on the Supreme Court.

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ARGUMENT

Before being appointed to the Supreme Court, President Barack Obama had nominated Justice Elena Kagan to serve as Solicitor General of the United States, a position designated with the task of supervising and conducting government litigation before the Supreme Court. Indeed, the website of the Office of Solicitor General even indicates "Virtually all such litigation is channeled through the Office of the Solicitor General and is actively conducted by the Office."

While serving as Solicitor General, Justice Kagan took significant part in health care reform issues and the crafting of the Act, participating even by her own concession in at least one meeting in which what became the Act was discussed. It is also believed that before the Act was even passed, the Department of Justice had, in fact, been meeting to develop a strategy for defending the law from constitutional attacks. Involved in these efforts was Justice Kagan.

In addition to receiving privileged internal strategy with regard to the constitutionality of the Act, Justice Kagan also expressed her favoritism towards the law's passage through several exchanges and emails.

Given her extensive participation in the passage of the Act in addition to her incriminating exchanges and emails evidencing her favoritism towards the constitutionality of the law, it is clear that Justice Kagan should recuse herself under 28 U.S.C. §455 and the Constitution of the United States, or otherwise be disqualified.

I. SECTION 455(a) OF TITLE 28 REQUIRES JUSTICE KAGAN'S RECUSAL OR DISQUALIFICATION

Amicus, Freedom Watch, respectfully requests that Justice Elena Kagan recuse herself from the case pursuant to 28 U.S.C. §455, or be disqualified. §455 (a) of Title 28 United States Code mandates that "any justice, judge, or magistrate [magistrate judge] of the United States shall disqualify himself in any proceedings in which his impartiality might reasonably be questioned." The significant aspect of §455(a) is not the reality of bias or prejudice but its appearance. *Microsoft Corp. v. United States*, 530 U.S. 1301, 1302 (2000), citing *Liteky v. United States*, 510 U.S. 540, 548 (1994). The recusal or disqualification inquiry must be made from the perspective of a reasonable observer who is informed of all surrounding facts and circumstances. *Cheney v. United States Dist. Court*, 541 U.S. 913, 924, citing *Microsoft Corp.*, 530 U.S. at 1302. Furthermore, as this Court has recognized,

> Subsection (a) was drafted to replace the subjective standard of the old disqualification statute with an objective test. Congress

> hoped that this objective standard would promote public confidence in the impartiality of the judicial process by instructing a judge, when confronted with circumstances in which his impartiality *could reasonably be doubted*, to disqualify himself and allow another judge to preside over the case.

Liljeberg v. Health Servs. Acquisition Corp., 486 U.S. 847, 870 (1988) (emphasis added). The appearance of Justice Kagan's participation in this case must therefore be seen objectively, from the perspective of a reasonable observer who is informed of all surrounding facts and circumstance.

Justice Kagan's employment as the Solicitor General, the person appointed specifically to represent the government in the Supreme Court, is an objective indicator of a conflict of interest within the current lawsuit. Thus, a reasonable person could reasonably question Justice Kagan's impartiality. Freedom Watch, speaking on behalf of the American people, perceives this situation as another in which there is, at the very least, an *appearance* of impartiality. This appearance of partiality should cause Justice Kagan to recuse herself or be disqualified from this decision.

II. JUSTICE KAGAN'S RECUSAL OR DISQUALIFICATION IS SIMILARLY MANDATED UNDER 28 U.S.C. §455(b)(1)

Additionally, §455(b) requires recusal whenever a judge "has a personal bias or prejudice concerning a party, or personal knowledge of disputed evidentiary facts concerning the proceeding." This Court has further elaborated that §455(b)(1) requires recusal where the official has "a favorable or unfavorable disposition or opinion that is somehow wrongful or inappropriate, either because it is undeserved or because it rests upon knowledge that the subject ought not to possess . . . or because it is excessive in degree." *Liteky*, 510 U.S. at 550. Before being appointed to the Supreme Court, Justice Kagan served as the U.S. Solicitor General. While it has long been insinuated that Justice Kagan participated in discussions regarding President Obama's health care legislation, documents have recently come to light unequivocally evidencing Justice Kagan's strong support of the Act. These incriminating documents, in pertinent part, are listed below:

- On October 13, 2009, there was an exchange between Justice Kagan and former Deputy Solicitor General Neal Katyal. Katyal informs Justice Kagan, "We just got Snowe on health care." (referring to Senator Olympia Snowe).
- On March 21, 2010, there was an email from Justice Kagan to then senior counselor for Access to Justice Laurence Tribe: "I hear they have votes Larry!! Simply amazing . . . " Tribe then responded with, "So healthcare is basically done! Remarkable."
- On March 16, 2010, there was an email from Justice Kagan to David Barron, asking if he had seen an article by Michael McConnell

> published in the Wall Street Journal that discussed a strategy by Democrats to "Deem ObamaCare into law without voting." Justice Kagan writes in the subject line "Health care q." Barron responded with, "YES, HE IS GETTING THIS GOING."

Exhibit 1. In objectively examining these statements and the circumstances surrounding this case, there is no doubt that a reasonable person would question the blatant partiality of Justice Kagan. Significantly, this case seeks to determine the constitutionality of such legislation, particularly the individual mandate provision. Moreover, the issue of severability will also be examined, deciding the survivability of the rest of the Act if the provision were to fail. Justice Kagan has not been in the least bit subtle in her opinion regarding the Act, brazenly displaying her support of the legislation. Thus, judicial fairness mandates recusal or disqualification in order to preserve impartiality and the appearance of impartiality.

III. JUSTICE KAGAN'S RECUSAL OR DISQUALIFICATION WOULD ALSO BE MANDATED UNDER 28 U.S.C. §455(b)(3)

While serving as the Solicitor General, Justice Kagan was intimately involved with health care reform issues, participating, by her own concession, in at least one meeting in which the healthcare legislation was discussed. Perhaps most damning, however, is that Justice Kagan received privileged internal strategy about the case regarding the constitutionality of the Act, indicative of her intensive participation. This is evidenced by the Obama Administration's redacted portions of Justice Kagan's emails under the Freedom of Information Act's exemption that specifically prevents disclosure of government deliberations.

Section 455(b)(3) of Title 28 requires recusal or disqualification when a judge, justice, or magistrate previously employed as government employee served as "counsel, advisor, or material witness concerning the proceeding." Justice Kagan's position as Solicitor General clearly serves as governmental employment. In this capacity, Justice Kagan served as "counsel, advisor, or material witness" when she received privileged information and even aided in the crafting of a legal defense to the constitutionality of the Act.

This same disqualification should apply even if, as Justice Kagan contends, she had no active role in the defense of the case. Indeed, this Court has previously held that "[n]ot only is a biased decisionmaker constitutionally unacceptable but 'our system of laws has always endeavored to prevent *even the probability* of unfairness.'" *Withrow v. Larkin*, 421 U.S. 35, 47 (1975), citing *In re Murchison*, 349 U.S. 133, 136 (emphasis added). As this Court stated in *Withrow*, "even the probability of unfairness" was enough to disqualify a justice. Here, Justice Kagan's participation in her role as Solicitor General goes far beyond creating a simple "probability" and her personal statements during that time make it rather probable that unfairness exists if she were to rule in this matter.

As such, given her prior position as Solicitor General, the legal advisor and counsel to the President, in addition to her incriminating exchanges and emails, which evidence her strong support of the health care law, Justice Kagan's impartiality is more than questionable: her bias is clearly established. For these reasons, 28 U.S.C. §455 requires Justice Kagan's recusal in this case.

IV. THE DUE PROCESS CLAUSE OF THE FIFTH AMENDMENT REQUIRES RECUSAL OR DISQUALIFICATION WHEN THERE IS AN UNCONSTITUTIONAL PROBABILITY OF BIAS

In addition to the claims brought under 28 U.S.C. §455, Justice Kagan's recusal is also mandated by the Due Process Clause of the Fifth Amendment because of the unconstitutional probability of bias that exists because of her involvement as Solicitor General of the United States.

Due Process disqualification is reserved for "extraordinary situation[s] when the Constitution requires recusal." *Caperton v. A. T. Massey Coal Co.*, 129 S. Ct. 2252 (2009). This Court further elaborated in *Caperton* that "[j]ust as no man is allowed to be a judge in his own cause, similar fears of bias can arise when – without the other parties' consent – a man chooses the judge in his own cause." *Id.* at 2256. The Patient Protection and Affordable Care Act of 2010 was President Obama's signature legislation. He championed for the Act and signed it with great fanfare. Yet many opposed this Act and President Obama's initiatives surely suspected it may head to this Court. Thus, by nominating a justice who had been a fellow proponent of the legislation, President Obama was choosing "the judge in his own cause." This creates, at the very least, an appearance of a quid pro quo, with the public having a reasonable belief that President Obama selected Justice Kagan in exchange for her ruling on the constitutionality of the Act.

As the court noted in *Caperton*, when extreme fact situations arise the Due Process Clause of the Fourteenth Amendment acts to disqualify a biased decisionmaker. While *Caperton* arose out of a case that involved one of the states, and therefore utilized the Fourteenth Amendment, the case before the court now arises from the actions of the federal government. Thus, in the case at hand, the Fifth Amendment's Due Process Clause should serve to disqualify Justice Kagan in much the same way that the Fourteenth Amendment did in *Caperton*. The standards for judicial fairness should be the same regardless of which court is hearing the case.

President Obama's nomination of Ms. Kagan involves the president, the chief executive, and a future member of the highest court in our land. Thus, the head positions of two branches of our government are now involved. Furthermore, the Patient Protection and Affordable Care Act is poised to control one sixth of the U.S. economy and significantly alter how healthcare is provided to a large majority of the American People.

Justice Kagan's involvement in her role as Solicitor General, as well as her statements championing the passage of the Act are clearly more than sufficient to give rise to a recusal or disqualification. These facts surely arise to the level of "extraordinary situation" that was required in order for the Constitution to require recusal. The stakes of this case are so high that there should not be even the slightest hint of partiality. The American people will not stand for a biased ruling in a case of such magnitude.

V. THIS COURT SHOULD SEEK TO DISQUALIFY JUSTICE KAGAN IF SHE DOES NOT RECUSE HERSELF FROM THE PROCEEDINGS

The integrity of this and every other court must be protected. The Congress has provided multiple means to ensure mechanisms exist to uphold such a task. The first of these is 28 U.S.C. §144, which on its face *requires* disqualification once a party files a timely and sufficient affidavit, and certifies that the motion is filed in good faith. Specifically, §144 states:

> Whenever a party to any proceeding in a district court makes and files a timely and sufficient affidavit that the judge before whom the matter is pending has a personal bias or prejudice either against him or in favor of any adverse party, such judge shall proceed

> no further therein, but another judge shall be assigned to hear such proceedings.

28 U.S.C. §144. Indeed, district court judges are to automatically "proceed no further" as soon as this low threshold of a good faith affidavit is met. By requiring such a low threshold, Congress made the disqualification of a biased judge easily obtainable for even the ordinary citizen.

This was not Congress' only actions in hoping to preserve the integrity and utmost fairness in our courts of law. Section 455 of Title 28, discussed thoroughly above, was revised in 1974 to broaden the powers of the law as to ensure fairness in all levels of our court system. The revised §455 expanded upon Section 144 as it was made "applicable to *all* justices, judges, and magistrates (and not just district judges)" and "placed the obligation to identify the existence of those grounds upon the judge himself, rather than requiring recusal only in response to a party affidavit." *Liteky v. United States*, 510 U.S. at 548.

Unlike every other court in this land, the Supreme Court is the only one that does not have an ethics mechanism to ensure the integrity of the Court. It is this integrity that the justices of this court must serve to protect, and in the absence of an ethics mechanism the justices themselves must be the ones to ensure that there is no question as to the impartiality of the court.

The issue of impartiality in this case is just as important, if not more so, than the issues actually being heard. The strength of this Court's rulings all stem from the high regard that the citizens of the country hold in our judicial system. If the partiality of this Court comes into contention on this or any other decision, it is the Supreme Court as an institution that will suffer. Thus, in order to prevent further erosion of the integrity of the Court, this Court must seek to disqualify Justice Kagan if she does not recuse herself.

These days, the great majority of American people – well over 80 percent according to recent New York Times and USA Today Polling – have expressed a deep distrust of government, including the judicial system. The Supreme Court, by disqualifying Justice Kagan from the case, will help restore the people's trust in our institutions. And, if the justice is not disqualified, the Act, if held constitutional, will always be seen by "We the People" as a compromised and illegitimate piece of legislation.

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CONCLUSION

For all of the reasons set forth above, Justice Kagan has demonstrated an extra-judicial bias and prejudice and must respectfully recuse herself or be disqualified. The people must not lose faith in its judicial institutions, which were meant in large part to protect them from the tyranny of the other two branches of government. Justice Kagan's recusal in this matter is required under 28 U.S.C. §455(a) because her impartiality might reasonably be questioned. Furthermore, §455(b)(1) requires Justice Kagan's recusal or disqualification because of the personal bias demonstrated in her emails. In addition, §455(b)(3) requires Justice Kagan's recusal or disqualification because her role as Solicitor General made her an employee of the government, in which capacity she served as "counsel, adviser or material witness" to the Act which is now being heard in this Court.

Finally, the Due Process Clause of the Fifth Amendment requires the recusal or disqualification of Justice Kagan since her involvement in such a significant case creates the extreme fact pattern that is required for recusal or disqualification.

Since the Supreme Court is the highest court of this land, and is not answerable to a "higher authority," Freedom Watch submits that the Court itself must disqualify Justice Kagan if she does not recuse herself. The United States boasts that our court system is the greatest in the world. In order to maintain the integrity that is required to keep this Court above all reproach, Justice Kagan must not sit for this decision particularly in these difficult times. To do so would risk irreparably compromising this institution devised and crafted by our Founding Fathers to protect "We the People."

Freedom Watch respectfully requests ten (10) minutes of Oral Argument.

Respectfully submitted,

LARRY KLAYMAN, ESQ.
Chairman and General Counsel
FREEDOM WATCH
2020 Pennsylvania Ave., N.W., Suite 345
Washington, D.C. 20006
leklayman@yahoo.com
(310) 595-0800

Counsel for Amicus Curiae January 6, 2012

EXHIBIT 1

[redacted]

From: Katyal, Neal
Sent: Tuesday, October 13, 2009 1:06 PM
To: Kagan, Elena
Subject: RE: At some point soon

we just got snowe on health care

From: Kagan, Elena
Sent: Tuesday, October 13, 2009 12:55 PM
To: Katyal, Neal
Subject: RE: At some point soon

In person. I'll call a meeting when I return.

From: Katyal, Neal
To: Kagan, Elena
Sent: Tue Oct 13 12:43:00 2009
Subject: At some point soon

We should talk also about whether to extend the offer to [redacted]. I'm definitely in favor of this, and doing it sooner will be good so that we don't have much of a gap. I also worry that he might be looking elsewhere since he seemed ready to leave his current position during the interviews. If you are in agreement, we could probably do this conversation over email with the other deputies to make sure they are on board (it sure sounded like they were in our August hiring meeting), or we can do it in person at a future meeting of us all.

N

From: Barron, David
Sent: Tuesday, March 16, 2010 1:40 PM
To: Kagan, Elena
Subject: RE: Health care q

YES – HE IS GETTING THIS GOING.

From: Kagan, Elena
Sent: Tuesday, March 16, 2010 1:06 PM
To: Barron, David
Subject: Health care q

Did you seee michael mcconnell's piece in the wsj?

[redacted]

From: Elena Kagan [redacted]
Sent: Sunday, March 21, 2010 11:04 PM
To: [redacted]; Larry Tribe; Elena Kagan
Cc: [redacted]; Henthorne, Betsy L. (SMO)
Subject: Re: fingers and toes crossed today!

I can do April 12

From: [redacted]
Date: Sun, 21 Mar 2010 23:00:58 -0400
To: Larry Tribe[redacted]; [redacted]
Cc: [redacted]
Subject: RE: fingers and toes crossed today!

[redacted] would be available on April 7 or 12. Look forward to hearing from you regarding what works best for the rest of the group.

Best,
[redacted]

[redacted]

From: Larry Tribe [mailto[redacted]]
Sent: **Sunday, March 21, 2010 5:06 PM**
To: **ekagan**[redacted]
Cc: [redacted]
Subject: **RE: fingers and toes crossed today!**

So health care is basically done! Remarkable. And with the Stupak group accepting the magic of what amounts to a signing statement on steroids!

Re dinner, I now remember the place you'd suggested back in December: Founding Farmers. I still like the name and don't recall why I'd thought the place in the Mandarin would be worth trying. So how about our going to Founding Farmers with you and [redacted]? I'd suggest April 4, 7, 9, 12 and 23 as possible dates. I don't have [redacted] [redacted] email but I'm hoping the [redacted] email will reach her indirectly and am also copying her assistant [redacted] just in case.

From: Elena Kagan [redacted]
Sent: Sunday, March 21, 2010 11:39 AM
To: Larry Tribe
Subject: Re: fingers and toes crossed today!

I hear they have the votes, Larry!! Simply amazing. Let's go wherever you want; I think you mentioned a place in the Mandarin, which would be great. Give me any dates you want after March 31. [redacted] [redacted] expressed an interest in joining as well.

From: Larry Tribe [redacted]
Date: Sun, 21 Mar 2010 13:02:09 +0000
To: elena.kagan@usdoj.gov<elena.kagan@usdoj.gov>;
[redacted]
Subject: fingers and toes crossed today!

Also: [redacted] and I haven't forgotten that dinner with you that we had to postpone. Where were we going to meet? I recall that it was someplace you'd not yet visited but wanted to try out. Let's find a date to get together there before too long. . . . Larry

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JOINT
APPENDIX

RECORD AND BRIEFS

Nos. 11-393, 11-398 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
ET AL., PETITIONERS
v.
KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL., PETITIONERS
v.
STATE OF FLORIDA, ET AL.

STATE OF FLORIDA, ET AL., PETITIONERS
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

JOINT APPENDIX

(Minimum Coverage Provision, Anti-Injunction Act, Severability)

DONALD B. VERRILLI, JR.
Solicitor General
Department of Justice
Washington, D.C. 20530-0001
SupremeCtBriefs@usdoj.gov
(202) 514-2217

Counsel of Record
for Federal Parties

PAUL CLEMENT
Bancroft PLLC
1919 M Street, N.W.
Washington D.C. 20036
pclement@bancroftpllc.com
(202) 234-0090

Counsel of Record for
State Parties

(Additional Counsel Listed on Inside Cover)

PETITIONS FOR WRITS OF CERTIORARI FILED: SEPT. 27 & 28, 2011
CERTIORARI GRANTED: NOV. 14, 2011

Library of Congress
Law Library

MICHAEL CARVIN
Jones Day
51 Louisiana Ave. NW
Washington, D.C. 20001
macarvin@jonesday.com
(202) 879 3939

Counsel of Record for
Private Parties

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UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 11-11021

STATE OF FLORIDA, ET AL., PLAINTIFFS-APPELLANTS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANT-APPELLEE

DOCKET ENTRIES

DATE	PROCEEDINGS
3/9/11	CIVIL APPEAL DOCKETED. Notice of appeal filed by Appellants Timothy F. Geithner, Kathleen Sebelius, Hilda Solis, United States Department of Health and Human Services, United States Department of Labor and United States Department of the Treasury on 03/08/2011. Appellant brief due 40 days from 03/09/2011. Fee Status: Fee Not Required.

* * * * *

DATE	PROCEEDINGS
3/11/11	MB MOTION for initial hearing en banc filed by Attorney Scott Douglas Makar for Appellees State of Florida, State of Texas, State of South Carolina, State of Nebraska and State of Utah. Opposition to Motion is Unknown [6258405-1]

DATE	PROCEEDINGS
	* * * * *
3/14/11	Appellee National Federation of Independent Business added to case.
3/14/11	Appellee Kaj Ahlburg added to case.
3/14/11	Appellee Mary Brown in 11-11021 and Appellee Mary Brown in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
3/18/11	Response to Petition for Rehearing filed as to Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021. [11-11021, 11-11067]
	* * * * *
3/31/11	ORDER: The Court having been polled at the request of several members of the Court and a majority of the Circuit Judges who are in regular service not having voted in favor of it, (Rule 35, F.R.A.P.), Appellees' Motion for Initial Hearing En Banc is DENIED [6258405-2]. Consistent with the Court's March 11, 2011, order granting in part Appellants' motion to ex-

DATE	PROCEEDINGS
	pedite this appeal, this appeal shall also be expedited to oral argument and shall be heard at oral argument on Wednesday, June 8, 2011, at 9:30 A.M. in Atlanta, Georgia before a three judge panel randomly selected. Each side will be given one hour to present oral arguments. Further, consistent with Eleventh Cir. I.O.P. 7 (Identity of Panel), following Fed. R. App. 34, the identity of the panel which will hear oral argument will be disclosed no earlier than fourteen days in advance of oral argument. JFD. [11-11021, 11-11067]

* * * * *

DATE	PROCEEDINGS
4/4/11	Appellant's brief filed by United States Department of Health and Human Services in 11-11021. Service date: 04/01/2011 [11-11021] Attorney for Appellee: Cobb - US mail; Attorney for Appellee: Katsas - US mail; Attorney for Appellant: Rivkin - US mail; Attorney for Appellee: Spohn - US mail; Attorney for Appellant: Winship - US mail; [11-11067] Attorney for Appellant: Rivkin - US mail; Attorney for Appellant: Winship - US mail; Attorney for Appellee: Katsas - US mail; Attorney for Appellee: Spohn - US mail. [11-11021, 11-11067]

DATE	PROCEEDINGS
4/4/11	Expanded Record Excerpts filed by Attorney Thomas Mark Bondy for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021. Service date: 04/01/2011 US mail - Attorney for Appellant(s): Rivkin, Winship; Attorney for Appellee(s): Cobb, Katsas, Spohn. [11-11021, 11-11067]

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4/7/11	Amicus Brief filed by Amicus Curiae American Association of People with Disabilities etc. Service date: 04/06/2011 US mail - Attorney for Amicus Curiae: Bobroff. [11-11021, 11-11067]
4/7/11	Removed Appellants Timothy F. Geithner, Kathleen Sebelius and Hilda Solis in 11-11021.
4/8/11	Appellant SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES added to case.
4/8/11	Appellant SECRETARY OF THE UNITED STATES DEPARTMENT OF TREASURY added to case.

DATE	PROCEEDINGS
4/8/11	Appellant SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR added to case.
4/8/11	Amicus Curiae The National Indian Health Board in 11-11021 and Amicus Curiae The National Indian Health Board in 11-11067 added to case. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/8/11	Amicus Brief filed by Amicus Curiae The National Indian Health Board. Service date: 04/07/2011 US mail - Attorney for Amicus Curiae: Strommer.
4/8/11	Amicus Curiae State Legislators in 11-11021 and Amicus Curiae State Legislators in 11-11067 added to case. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/8/11	Amicus Brief filed by Amicus Curiae State Legislators in 11-11021, 11-11067. Service date: 04/07/2011 US mail - Attorney for Amicus Curiae: Wydra. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/8/11	Amicus Brief filed by Amicus Curiae American Nurses Association in 11-11021, 11-11067. Service date: 04/07/2011 US mail - Attorney for Amicus Curiae: Millhiser. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Curiae Missouri Attorney General in 11-11021 and Amicus Curiae Missouri Attorney General in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Missouri Attorney General in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Hirth. [11-11021, 11-11067]
4/11/11	Amicus Curiae Economic Scholars in 11-11021 and Amicus Curiae Economic Scholars in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Economic Scholars in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Horton. [11-11021, 11-11067]

DATE	PROCEEDINGS
4/11/11	Amicus Curiae AARP in 11-11021 and Amicus Curiae AARP in 11-11067 added to case. [11-11021, 11-11067]
4/11/11	Amicus Brief filed by Amicus Curiae AARP in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Cohen. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Curiae Constitutional Law Professors added to case.
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Constitutional Law Professors. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Kimberly.
4/11/11	Amicus Brief filed by Amicus Curiae Services Employees International Union in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Weissglass. [11-11021, 11-11067]
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DATE	PROCEEDINGS
4/11/11	Amicus Curiae State of Oregon in 11-11021 and Amicus Curiae State of Oregon in 11-11067 added to case. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/11/11	Amicus Brief filed by Amicus Curiae State of Oregon in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Dubanevich. [11-11021, 11-11067]
4/11/11	Amicus Curiae The Commonwealth of Massachusetts added to case.
4/11/11	Amicus Brief filed by Amicus Curiae The Commonwealth of Massachusetts. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Stephan.
4/11/11	Amicus Curiae Professors of Federal Jurisdiction in 11-11021 and Amicus Curiae Professors of Federal Jurisdiction in 11-11067 added to case. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/11/11	Amicus Brief filed by Amicus Curiae Professors of Federal Jurisdiction in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Bland. [11-11021, 11-11067]

DATE	PROCEEDINGS
4/11/11	Amicus Curiae Kevin C. Walsh in 11-11021 and Amicus Curiae Kevin C. Walsh in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Kevin C. Walsh in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Mills. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Curiae American Hospital Association in 11-11021 and Amicus Curiae American Hospital Association in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae American Hospital Association in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Stetson. [11-11021, 11-11067]

DATE	PROCEEDINGS
4/11/11	Amicus Curiae Harry Reid in 11-11021 and Amicus Curiae Harry Reid in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Harry Reid in 11-11021, Amicus Curiae State Legislators in 11-11067. Service date: 04/09/2011 US mail - Attorney for Amicus Curiae: Dellinger. [11-11021, 11-11067]
4/11/11	Amicus Curiae Brief of Law Professors in 11-11021 and Amicus Curiae Brief of Law Professors in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Brief of Law Professors in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Lamken. [11-11021, 11-11067]

DATE	PROCEEDINGS
4/11/11	Amicus Curiae Chamber of Commerce in 11-11021 and Amicus Curiae Chamber of Commerce in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Chamber of Commerce in 11-11021, 11-11067. Service date: 04/09/2011 US mail - Attorney for Amicus Curiae: Blalack. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Curiae American Academy of Pediatrics in 11-11021 and Amicus Curiae American Academy of Pediatrics in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae American Academy of Pediatrics in 11-11021, 11-11067. Service date:

DATE	PROCEEDINGS
4/8/11	US mail - Attorney for Amicus Curiae: Perkins. [11-11021, 11-11067]
	* * * * *
4/12/11	Record on Appeal filed. Pleadings, 9 volumes; Transcript, 3 volumes [11-11021, 11-11067, 11-11280]
	* * * * *
4/18/11	Amicus Curiae Governor of the State of Washington in 11-11021 and Amicus Curiae Governor of the State of Washington in 11-11067 added to case. [11-11021, 11-11067]
4/18/11	Amicus Brief filed by Amicus Curiae Governor of the State of Washington in 11-11021, 11-11067. Service date: 04/11/2011 US mail - Attorney for Amicus Curium: Berger, Dellinger, Dubanevich, Hirth, Horton, Kimberly, Lamken, Millhiser, Mills, Perkins, Philo, Stephan, Stetson, Strommer, Weissglass, Wydra. [11-11021, 11-11067]

DATE	PROCEEDINGS

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4/19/11	Amicus Brief filed by Amicus Curiae American Cancer Society in 11-11021. Service date: 04/11/2011 US mail - Attorney for Amicus Curiae: Suda. [11-11021, 11-11067]
4/19/11	Amicus Brief filed by Amicus Curiae Young Invincibles in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Annino. [11-11021, 11-11067]

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4/19/11	Amicus Brief filed by Amicus Curiae The National Women's Law Center in 11-11021. Service date: 04/11/2011 US mail - Attorney for Amicus Curiae: Hart. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/4/11	Appellee's Brief filed by Appellees Kaj Ahlburg, Mary Brown and National Federation of Independent Business. Service date: 05/04/2011 US mail - Attorney for Appellant: Bondy.
5/4/11	Appellee-Cross Appellant's Brief filed by Appellees State of Florida, State of Nebraska, State of South Carolina, State of Texas and State of Utah in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. Service date: 05/04/2011 US mail - Attorney for Appellant: Katyal. [11-11021, 11-11067]

DATE	PROCEEDINGS
	* * * * *
5/5/11	Amicus Brief filed by Amicus Curiae American Center for Law and Justice in 11-11021, 11-11067. Service date: 05/04/2011 US mail - Attorney for Amicus Curiae: White. [11-11021, 11-11067]
	* * * * *
5/10/11	Amicus Brief filed by Amicus Curiae South Carolina Chamber of Commerce in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Christina. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae American Civil Rights Union in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Tragos. [11-11021, 11-11067]
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DATE	PROCEEDINGS
5/11/11	Amicus Brief filed by Amicus Curiae Justice and Freedom Fund in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Dewart. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/11/11	Amicus Brief filed by Amicus Curiae American Legislative Exchange Council in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Elwood. [11-11021, 11-11067]
5/11/11	Amicus Brief filed by Amicus Curiae Landmark Legal Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Hutchison. [11-11021, 11-11067]
5/11/11	Amicus Curiae Matthew Sissel in 11-11021 and Amicus Curiae Matthew Sissel in 11-11067 added to case. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/11/11	Amicus Brief filed by Amicus Curiae Matthew Sissel in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Sandefur. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae Catholic Medical Association in 11-11021, 11-11067. Service date: 05/09/2011 US mail - Attorney for Amicus Curiae: Bordlee. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae Physician Hospitals of America in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Moldovan. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae Minnesota Legislators in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attor-

DATE	PROCEEDINGS
	ney for Amicus Curiae: Bader. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/11/11	Amicus Brief filed by Amicus Curiae The Heritage Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Strickland. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/11/11	Amicus Brief filed by Amicus Curiae The Independence Institute in 11-11021. Service date: 05/09/2011 US mail - Attorney for Amicus Curiae: Kopel. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/12/11	Amicus Brief filed by Amicus Curiae Doctors for Patient Care in 11-11021. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Jaffe. [11-11021, 11-11067]

DATE	PROCEEDINGS
5/12/11	Amicus Brief filed by Amicus Curiae Cato Institute in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Shapiro. [11-11021, 11-11067]
	* * * * *
5/12/11	Amicus Brief filed by Amicus Curiae Washington Legal Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Andrews. [11-11021, 11-11067]
	* * * * *
5/12/11	Amicus Brief filed by Amicus Curiae Revere America Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Cooper. [11-11021, 11-11067]
5/12/11	Amicus Brief filed by Amicus Curiae Family Research Council in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Klukowski. [11-11021, 11-11067]

DATE	PROCEEDINGS

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5/12/11	Amicus Brief filed by Amicus Curiae The Association of American Physicians & Surgeons, Inc. in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Tripp. [11-11021, 11-11067]

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5/12/11	Amicus Brief filed by Amicus Curiae Economists in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Engel. [11-11021, 11-11067]

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5/13/11	Amicus Brief filed by Amicus Curiae James F. Blumstein in 11-11021. Service date: 05/09/2011 US mail - Attorney for Amicus Curiae: Blumstein. [11-11021, 11-11067]

DATE	PROCEEDINGS
5/13/11	Amicus Brief filed by Amicus Curiae Mountain States Legal foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Lechner. [11-11021, 11-11067]
	* * * * *
5/13/11	Amicus Brief filed by Amicus Curiae Caesar Rodney Institute in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Misir. [11-11021, 11-11067]
	* * * * *
5/13/11	Amicus Brief filed by Amicus Curiae Center for Individual Rights in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Rosman. [11-11021, 11-11067]
	* * * * *
5/13/11	Amicus Brief filed by Amicus Curiae Center for Constitutional Jurisprudence in 11-11021, 11-11067. Service date:

DATE	PROCEEDINGS
	05/11/2011 US mail - Attorney for Amicus Curiae: Caso. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/13/11	PT'D Amicus Brief filed by Amicus Curiae Members of the United States Senate in 11-11021. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Severino. [11-11021, 11-11067]
5/13/11	PT'D Amicus Brief filed by Amicus Curiae John Boehner in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Severino. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/16/11	Amicus Brief filed by Amicus Curiae Texas Public Policy Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Loyola. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/16/11	Amicus Brief filed by Amicus Curiae Idaho Freedom Foundation, Inc. in 11-11021. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Talmon. [11-11021, 11-11067]
	* * * * *
5/18/11	Appellant-Cross Appellee's Brief filed by Appellant United States Department of Health and Human Services in 11-11021. Service date: 05/17/2011 US mail - Attorney for Appellees: Clement, Katsas, Rivkin, Spohn, Winship. [11-11021, 11-11067]
	* * * * *
5/18/11	Amicus Brief filed by Amicus Curiae k Rohlfs in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Rohlfs. [11-11021, 11-11067]
5/19/11	ORDER: Motion to file amicus brief (John Boehner & Members of the U.S. Senate) filed by Carrie Lynn Severino is DENIED as UNNECESSARY. Be-

DATE	PROCEEDINGS
	cause the same atty has submitted more than one amicus curiae brief . . . counsel is directed to file and serve by 5/23 a single compliant amici curiae brief . . . brief is to be physically delivered to the Clerk's office by that date-5/23. [6302884-2] [11-11021, 11-11067]
	* * * * *
5/23/11	CORRECTED Amicus Brief filed by Amicus Curium John Boehner and Members of the United States Senate in 11-11021, Amicus Curiae John Boehner in 11-11067. Service date: 05/20/2011 US mail - Attorney for Amicus Curiae: Severino. [11-11021, 11-11067]
	* * * * *
5/25/11	Reply Brief filed by Appellants/Cross-Appellees Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State

DATE	PROCEEDINGS
	of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah and State of Wisconsin in 11-11067. Service 05/24/2011 US mail - Attorney for Appellees: Carvin, Kaersvang, Katsas, Marshall, Mooppan. [11-11021, 11-11067]
	* * * * *
5/31/11	Oral argument scheduled. Argument Date: Wednesday, 06/08/2011 Argument Location: Atlanta Courtroom: Atlanta 338. [11-11021, 11-11067] 5/31/11
	* * * * *
6/8/11	Oral argument held. Oral Argument participants were Neal Kumar Katyal for Appellants United States Department of Labor, et al., Michael Anthony Carvin for Appellees National Federation of Independent Business, et al., and Paul D. Clement for Appellees State of Florida

DATE	PROCEEDINGS
	and State of Utah, et al. in 11-11021. [11-11021, 11-11067]
6/21/11	Supplemental Authority filed by Appellees Kaj Ahlburg and Mary Brown in 11-11021, Appellee Mary Brown in 11-11067. Service date: 06/17/2011 US mail - Attorney for Appellants: Bondy, Casey, Clement, Grossman, Jacquot, Kaersvang, Kennedy, Makar, Osterhaus, Rivkin, Winship. [11-11021, 11-11067]
7/7/11	Supplemental Authority filed by Appellant United States Department of Health and Human Services in 11-11021. Service date: 07/06/2011 email - Attorney for Appellees: Clement, Katsas. [11-11021, 11-11067]
7/13/11	Response to Supplemental Authority (28J) filed by Appellee Kaj Ahlburg in 11-11021, Appellee Mary Brown in 11-11067. Service date: 07/12/2011 US mail - Attorney for Appellants: Chaifetz, Clement. [11-11021, 11-11067]

DATE	PROCEEDINGS
8/9/11	Supplemental Authority filed by Appellant SECRETARY OF THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES in 11-11021. Service date: 08/08/2011 US mail - Attorney for Appellees: Clement, Osterhaus, Rivkin. [11-11021, 11-11067]
8/12/11	Opinion issued by court as to Appellants SECRETARY OF THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, Secretary, U.S. Department of Labor, Secretary, US Department of Treasury, U.S. Department of Labor, US Department of Treasury and United States Department of Health and Human Services in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South

DATE	PROCEEDINGS
	Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. Decision: Affirmed in part and Reversed in part. Opinion type: Published. Opinion method: Signed. [11-11021, 11-11067]
8/12/11	Judgment entered as to Appellant SECRETARY OF THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES etc., in 11-11021. [11-11021, 11-11067]
	* * * * *
9/28/11	Notice of Writ of Certiorari filed as to Appellant United States Department of Health and Human Services. SC# 11-398.
9/28/11	Notice of Writ of Certiorari filed as to Appellee National Federation of Independent Business. SC# 11-393.
10/3/11	MOTION to stay mandate filed by Appellee United States Department of Health and Human Services in 11-11067. Motion

DATE	PROCEEDINGS
	is Unopposed [6398537-1] [11-11021, 11-11067]
	* * * * *
10/5/11	ORDER: On Oct. 4, 2011, the parties filed a joint mot to stay the issuance of the mandate . . . Accordingly, on or before Noon, Eastern Standard Time on Wednesday, Oct. 12, 2011, the parties are directed to jointly submit in writing to the court the reasons why they contend there is good cause for a stay (see file for complete text). JFD [11-11021, 11-11067]
10/11/11	Response pursuant to court order of 10/05/2011 filed by Dana Kaersvang for U.S. Department of Labor, United States Department of Health and Human Services and US Department of Treasury in 11-11067,.,SKIP) [11-11021, 11-11067]
10/13/11	ORDER: Motion to stay mandate filed by Appellee United States Department of Health and Human Services is DENIED [6398537-2] JFD, FMH and SM [11-11021, 11-11067]

DATE	PROCEEDINGS
10/24/11	Mandate issued as to Appellants Secretary U.S. Department of Health and Human Services, Secretary, U.S. Department of Labor, Secretary, US Department of Treasury, U.S. Department of Labor, US Department of Treasury and United States Department of Health and Human Services in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. [11-11021, 11-11067]

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DATE	PROCEEDINGS
11/14/11	**Writ of Certiorari filed as to Appellee National Federation of Independent Business is GRANTED. SC# 11-393.—[Edited 12/08/2011 by RAV]**
11/14/11	**Writ of Certiorari filed as to Appellant Secretary U.S. Department of Health and Human Services is GRANTED. SC# 11-398.—[Edited 12/08/2011 by RAV]**

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 11-11067

STATE OF FLORIDA, ET AL., PLAINTIFFS-APPELLANTS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANT-APPELLEE

DOCKET ENTRIES

DATE	PROCEEDINGS
3/11/11	**CIVIL APPEAL DOCKETED. Notice of appeal filed by Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming on 03/10/2011. Appellant brief due 40 days from 03/11/2011. Fee Status: Fee Paid.**

DATE	PROCEEDINGS
3/11/11	ORDER: Motion to expedite filed by Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury is GRANTED in part: aplt brf due 4/4, cross-aplt 5/4, cross-aple 5/18, reply brf 5/25, No ext., all brfs must be rcvd in Clerk's office . . . Aple's pet for initial hearing remains pndg . . . [6257236-2] in 11-11021 JFD [11-11021, 11-11067]
3/14/11	Appellee Mary Brown in 11-11021 and Appellee Mary Brown in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
3/18/11	Response to Petition for Rehearing filed as to Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021. [11-11021, 11-11067]
	* * * * *

DATE	PROCEEDINGS
3/31/11	ORDER: The Court having been polled at the request of several members of the Court and a majority of the Circuit Judges who are in regular service not having voted in favor of it, (Rule 35, F.R.A.P.), Appellees' Motion for Initial Hearing En Banc is DENIED [6258405-2]. Consistent with the Court's March 11, 2011, order granting in part Appellants' motion to expedite this appeal, this appeal shall also be expedited to oral argument and shall be heard at oral argument on Wednesday, June 8, 2011, at 9:30 A.M. in Atlanta, Georgia before a three judge panel randomly selected. Each side will be given one hour to present oral arguments. Further, consistent with Eleventh Cir. I.O.P. 7 (Identity of Panel), following Fed. R.App. 34, the identity of the panel which will hear oral argument will be disclosed no earlier than fourteen days in advance of oral argument. JFD. [11-11021, 11-11067]
	* * * * *
4/4/11	Appellant's brief filed by United States Department of Health and Human Services in 11-11021. Service date: 04/01/2011 [11-11021] Attorney for Appellee: Cobb - US mail; Attorney for Appellee: Katsas - US mail; Attorney for Appellant: Rivkin - US mail; Attorney for Appellee: Spohn -

DATE	PROCEEDINGS
	US mail; Attorney for Appellant: Winship - US mail; [11-11067] Attorney for Appellant: Rivkin - US mail; Attorney for Appellant: Winship - US mail; Attorney for Appellee: Katsas - US mail; Attorney for Appellee: Spohn - US mail. [11-11021, 11-11067]
4/04/11	Expanded Record Excerpts filed by Attorney Thomas Mark Bondy for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021. Service date: 04/01/2011 US mail - Attorney for Appellant(s): Rivkin, Winship; Attorney for Appellee(s): Cobb, Katsas, Spohn. [11-11021, 11-11067]
	* * * * *
4/07/11	Amicus Brief filed by Amicus Curiae American Association of People with Disabilities etc.. Service date: 04/06/2011 US mail - Attorney for Amicus Curiae: Bobroff. [11-11021, 11-11067]
4/08/11	Amicus Curiae American Association of People with Disabilities added to case.
4/08/11	Amicus Curiae The National Indian Health Board in 11-11021 and Amicus Cu-

DATE	PROCEEDINGS
	riae The National Indian Health Board in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/08/11	Amicus Curiae State Legislators in 11-11021 and Amicus Curiae State Legislators in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/08/11	Amicus Brief filed by Amicus Curiae State Legislators in 11-11021, 11-11067. Service date: 04/07/2011 US mail - Attorney for Amicus Curiae: Wydra. [11-11021, 11-11067]
	* * * * *
4/08/11	Amicus Brief filed by Amicus Curiae American Nurses Association in 11-11021, 11-11067. Service date: 04/07/2011 US mail - Attorney for Amicus Curiae: Millhiser. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Curiae Missouri Attorney General in 11-11021 and Amicus Curiae Missouri Attorney General in 11-11067 added to case. [11-11021, 11-11067]

DATE	PROCEEDINGS

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DATE	PROCEEDINGS
4/11/11	Amicus Brief filed by Amicus Curiae Missouri Attorney General in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Hirth. [11-11021, 11-11067]
4/11/11	Amicus Curiae Economic Scholars in 11-11021 and Amicus Curiae Economic Scholars in 11-11067 added to case. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/11/11	Amicus Brief filed by Amicus Curiae Economic Scholars in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Horton. [11-11021, 11-11067]
4/11/11	Amicus Curiae AARP in 11-11021 and Amicus Curiae AARP in 11-11067 added to case. [11-11021, 11-11067]
4/11/11	Amicus Brief filed by Amicus Curiae AARP in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Cohen. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/11/11	Amicus Brief filed by Amicus Curiae Services Employees International Union in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Weissglass. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Curiae State of Oregon in 11-11021 and Amicus Curiae State of Oregon in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae State of Oregon in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Dubanevich. [11-11021, 11-11067]
4/11/11	Amicus Curiae Professors of Federal Jurisdiction in 11-11021 and Amicus Curiae Professors of Federal Jurisdiction in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Professors of Federal Jurisdiction in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Bland. [11-11021, 11-11067]

DATE	PROCEEDINGS
4/11/11	Amicus Curiae Kevin C. Walsh in 11-11021 and Amicus Curiae Kevin C. Walsh in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae Kevin C. Walsh in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Mills. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Curiae American Hospital Association in 11-11021 and Amicus Curiae American Hospital Association in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae American Hospital Association in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Stetson. [11-11021, 11-11067]
4/11/11	Amicus Curiae Harry Reid in 11-11021 and Amicus Curiae Harry Reid in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *

DATE	PROCEEDINGS
4/11/11	Amicus Brief filed by Amicus Curiae Harry Reid in 11-11021, Amicus Curiae State Legislators in 11-11067. Service date: 04/09/2011 US mail - Attorney for Amicus Curiae: Dellinger. [11-11021, 11-11067]
4/11/11	Amicus Curiae Brief of Law Professors in 11-11021 and Amicus Curiae Brief of Law Professors in 11-11067 added to case. [11-11021, 11-11067]
4/11/11	Amicus Brief filed by Amicus Curiae Brief of Law Professors in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Lamken. [11-11021, 11-11067]
4/11/11	Amicus Curiae Chamber of Commerce in 11-11021 and Amicus Curiae Chamber of Commerce in 11-11067 added to case. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/11/11	Amicus Brief filed by Amicus Curiae Chamber of Commerce in 11-11021, 11-11067. Service date: 04/09/2011 US mail - Attorney for Amicus Curiae: Blalack. [11-11021, 11-11067]

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DATE	PROCEEDINGS
4/11/11	Amicus Curiae Commonwealth of Massachusetts added to case.
4/11/11	Amicus Brief filed by Amicus Curiae Commonwealth of Massachusetts. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Stephan.
	* * * * *
4/11/11	Amicus Curiae American Academy of Pediatrics in 11-11021 and Amicus Curiae American Academy of Pediatrics in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
4/11/11	Amicus Brief filed by Amicus Curiae American Academy of Pediatrics in 11-11021, 11-11067. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Perkins. [11-11021, 11-11067]
	* * * * *
4/12/11	Amicus Curiae Service Employees International Union added to case.
	* * * * *
4/12/11	Record on Appeal filed. Pleadings, 9 volumes; Transcript, 3 volumes [11-11021, 11-11067, 11-11280]

DATE	PROCEEDINGS
	* * * * *
4/18/11	Amicus Curiae Governor of the State of Washington in 11-11021 and Amicus Curiae Governor of the State of Washington in 11-11067 added to case. [11-11021, 11-11067]
4/18/11	Amicus Brief filed by Amicus Curiae Governor of the State of Washington in 11-11021, 11-11067. Service date: 04/11/2011 US mail - Attorney for Amicus Curium: Berger, Dellinger, Dubanevich, Hirth, Horton, Kimberly, Lamken, Millhiser, Mills, Perkins, Philo, Stephan, Stetson, Strommer, Weissglass, Wydra. [11-11021, 11-11067]
	* * * * *
4/19/11	Amicus Brief filed by Amicus Curiae American Cancer Society in 11-11021. Service date: 04/11/2011 US mail - Attorney for Amicus Curiae: Suda. [11-11021, 11-11067]
4/19/11	Amicus Brief filed by Amicus Curiae Young Invincibles in 11-11021. Service date: 04/08/2011 US mail - Attorney for Amicus Curiae: Annino. [11-11021, 11-11067]

DATE	PROCEEDINGS
	* * * * *
4/19/11	Amicus Brief filed by Amicus Curiae The National Women's Law Center in 11-11021. Service date: 04/11/2011 US mail - Attorney for Amicus Curiae: Hart. [11-11021, 11-11067]
	* * * * *
5/4/11	Appellee-Cross Appellant's Brief filed by Appellees State of Florida, State of Nebraska, State of South Carolina, State of Texas and State of Utah in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. Service date: 05/04/2011 US mail - Attorney for Appellant: Katyal. [11-11021, 11-11067]

DATE	PROCEEDINGS
	* * * * *
5/5/11	Amicus Brief filed by Amicus Curiae American Center for Law and Justice in 11-11021, 11-11067. Service date: 05/04/2011 US mail - Attorney for Amicus Curiae: White. [11-11021, 11-11067]
	* * * * *
5/10/11	Amicus Brief filed by Amicus Curiae South Carolina Chamber of Commerce in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Christina. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae American Civil Rights Union in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Tragos. [11-11021, 11-11067]
	* * * * *

DATE	PROCEEDINGS
5/11/11	Amicus Brief filed by Amicus Curiae Justice and Freedom Fund in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Dewart. [11-11021, 11-11067]
5/11/11	Amicus Brief filed by Amicus Curiae American Legislative Exchange Council in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Elwood. [11-11021, 11-11067]
5/11/11	Amicus Brief filed by Amicus Curiae Landmark Legal Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Hutchison. [11-11021, 11-11067]
5/11/11	Amicus Curiae Matthew Sissel in 11-11021 and Amicus Curiae Matthew Sissel in 11-11067 added to case. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae Matthew Sissel in 11-11021, 11-11067. Service date: 05/10/2011 US mail - Attorney for Amicus Curiae: Sandefur. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/11/11	Amicus Brief filed by Amicus Curiae Catholic Medical Association in 11-11021, 11-11067. Service date: 05/09/2011 US mail - Attorney for Amicus Curiae: Bordlee. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae Physician Hospitals of America in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Moldovan. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae Minnesota Legislators in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Bader. [11-11021, 11-11067]
	* * * * *
5/11/11	Amicus Brief filed by Amicus Curiae The Heritage Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Strickland. [11-11021, 11-11067]
	* * * * *

DATE	PROCEEDINGS
5/11/11	Amicus Brief filed by Amicus Curiae The Independence Institute in 11-11021. Service date: 05/09/2011 US mail - Attorney for Amicus Curiae: Kopel. [11-11021, 11-11067]
	* * * * *
5/12/11	Amicus Brief filed by Amicus Curiae Doctors for Patient Care in 11-11021. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Jaffe. [11-11021, 11-11067]
5/12/11	Amicus Brief filed by Amicus Curiae Cato Institute in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Shapiro. [11-11021, 11-11067]
	* * * * *
5/12/11	Amicus Brief filed by Amicus Curiae Washington Legal Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Andrews. [11-11021, 11-11067]
	* * * * *

DATE	PROCEEDINGS
5/12/11	Amicus Brief filed by Amicus Curiae Revere America Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Cooper. [11-11021, 11-11067]
5/12/11	Amicus Brief filed by Amicus Curiae Family Research Council in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Klukowski. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/12/11	Amicus Brief filed by Amicus Curiae The Association of American Physicians & Surgeons, Inc. in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Tripp. [11-11021, 11-11067]

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DATE	PROCEEDINGS
5/12/11	Amicus Brief filed by Amicus Curiae Economists in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Engel. [11-11021, 11-11067]
5/13/11	Amicus Brief filed by Amicus Curiae James F. Blumstein in 11-11021. Service date: 05/09/2011 US mail - Attorney for

DATE	PROCEEDINGS
	Amicus Curiae: Blumstein. [11-11021, 11-11067]
5/13/11	Amicus Brief filed by Amicus Curiae Mountain States Legal foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Lechner. [11-11021, 11-11067]
	* * * * *
5/13/11	Amicus Brief filed by Amicus Curiae Caesar Rodney Institute in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Misir. [11-11021, 11-11067]
	* * * * *
5/13/11	Amicus Brief filed by Amicus Curiae Center for Individual Rights in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Rosman. [11-11021, 11-11067]
	* * * * *
5/13/11	Amicus Brief filed by Amicus Curiae Center for Constitutional Jurisprudence in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Caso. [11-11021, 11-11067]

DATE	PROCEEDINGS
	* * * * *
5/13/11	PT'D Amicus Brief filed by Amicus Curiae Members of the United States Senate in 11-11021. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Severino. [11-11021, 11-11067]
5/13/11	PT"D Amicus Brief filed by Amicus Curiae John Boehner in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Severino. [11-11021, 11-11067]
	* * * * *
5/16/11	Amicus Brief filed by Amicus Curiae Texas Public Policy Foundation in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Loyola. [11-11021, 11-11067]
	* * * * *
5/16/11	Amicus Brief filed by Amicus Curiae Idaho Freedom Foundation, Inc. in 11-11021. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Talmon. [11-11021, 11-11067]
	* * * * *

DATE	PROCEEDINGS
5/18/11	Appellant-Cross Appellee's Brief filed by Appellant United States Department of Health and Human Services in 11-11021. Service date: 05/17/2011 US mail - Attorney for Appellees: Clement, Katsas, Rivkin, Spohn, Winship. [11-11021, 11-11067]
	* * * * *
5/18/11	Amicus Brief filed by Amicus Curiae k Rohlfs in 11-11021, 11-11067. Service date: 05/11/2011 US mail - Attorney for Amicus Curiae: Rohlfs. [11-11021, 11-11067]
5/19/11	ORDER: Motion to file amicus brief (John Boehner & Members of the U.S. Senate) filed by Carrie Lynn Severino is DENIED as UNNECESSARY. Because the same atty has submitted more than one amicus curiae brief . . . counsel is directed to file and serve by 5/23 a single compliant amici curiae brief . . . brief is to be physically delivered to the Clerk's office by that date-5/23. [6302884-2] [11-11021, 11-11067]
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DATE	PROCEEDINGS
5/23/11	CORRECTED Amicus Brief filed by Amicus Curium John Boehner and Members of the United States Senate in 11-11021, Amicus Curiae John Boehner in 11-11067. Service date: 05/20/2011 US mail - Attorney for Amicus Curiae: Severino. [11-11021, 11-11067]
	* * * * *
5/25/11	Reply Brief filed by Appellants/Cross-Appellees Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah and State of Wisconsin in 11-11067. Service 05/24/2011 US mail - Attorney for Appellees: Carvin, Kaersvang, Katsas, Marshall, Mooppan. [11-11021, 11-11067]
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DATE	PROCEEDINGS
5/31/11	Oral argument scheduled. Argument Date: Wednesday, 06/08/2011 Argument Location: Atlanta Courtroom: Atlanta 338. [11-11021, 11-11067]
	* * * * *
6/08/11	Oral argument held. Oral Argument participants were Neal Kumar Katyal for Appellants United States Department of Labor, et al., Michael Anthony Carvin for Appellees National Federation of Independent Business, et al., and Paul D. Clement for Appellees State of Florida and State of Utah, et al. in 11-11021. [11-11021, 11-11067]
6/21/11	Supplemental Authority filed by Appellees Kaj Ahlburg and Mary Brown in 11-11021, Appellee Mary Brown in 11-11067. Service date: 06/17/2011 US mail - Attorney for Appellants: Bondy, Casey, Clement, Grossman, Jacquot, Kaersvang, Kennedy, Makar, Osterhaus, Rivkin, Winship. [11-11021, 11-11067]
7/07/11	Supplemental Authority filed by Appellant United States Department of Health and Human Services in 11-11021. Service date: 07/06/2011 email - Attorney for Appellees: Clement, Katsas. [11-11021, 11-11067]

DATE	PROCEEDINGS
7/13/11	Response to Supplemental Authority (28J) filed by Appellee Kaj Ahlburg in 11-11021, Appellee Mary Brown in 11-11067. Service date: 07/12/2011 US mail - Attorney for Appellants: Chaifetz, Clement. [11-11021, 11-11067]
8/09/11	Supplemental Authority filed by Appellant SECRETARY OF THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES in 11-11021. Service date: 08/08/2011 US mail - Attorney for Appellees: Clement, Osterhaus, Rivkin. [11-11021, 11-11067]
8/12/11	Judgment entered as to Appellant SECRETARY OF THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES etc., in 11-11021. [11-11021, 11-11067]
	* * * * *
8/12/11	Opinion issued by court as to Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio,

DATE	PROCEEDINGS
	State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming. Decision: Affirmed in part and Reversed in part. Opinion type: Published. Opinion method: Signed.
9/29/11	Notice of Writ of Certiorari filed as to Appellant State of Florida. SC# 11-400.
10/03/11	MOTION to stay mandate filed by Appellee United States Department of Health and Human Services in 11-11067. Motion is Unopposed [6398537-1] [11-11021, 11-11067]
10/05/11	ORDER: On Oct. 4, 2011, the parties filed a joint mot to stay the issuance of the mandate . . . Accordingly, on or before Noon, Eastern Standard Time on Wednesday, Oct. 12, 2011, the parties are directed to jointly submit in writing to the court the reasons why they contend there is good cause for a stay (see file for complete text). JFD [11-11021, 11-11067]
10/11/11	Response pursuant to court order of 10/05/2011 filed by Dana Kaersvang for U.S. Department of Labor, United States Department of Health and Human Ser-

DATE	PROCEEDINGS
	vices and US Department of Treasury in 11-11067,.,SKIP) [11-11021, 11-11067]
10/13/11	ORDER: Motion to stay mandate filed by Appellee United States Department of Health and Human Services is DENIED [6398537-2] JFD, FMH and SM [11-11021, 11-11067]
10/24/11	Mandate issued as to Appellants Secretary U.S. Department of Health and Human Services, Secretary, U.S. Department of Labor, Secretary, US Department of Treasury, U.S. Department of Labor, US Department of Treasury and United States Department of Health and Human Services in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. [11-11021, 11-11067]

* * * * *

DATE	PROCEEDINGS
11/14/11	Writ of Certiorari filed as to Appellant State of Florida is GRANTED. SC# 11-400.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA

No. 3:10-cv-0091-RV-EMT

STATE OF FLORIDA, ET AL., PLAINTIFFS-APPELLANTS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANT-APPELLEE

DOCKET ENTRIES

DATE	DOCKET NUMBER	PROCEEDINGS
3/23/10	1	**COMPLAINT against TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY filed**

DATE	DOCKET NUMBER	PROCEEDINGS
		by STATE OF FLORIDA - Filing Fee $350, Receipt Number: 1129-1533627) (WINSHIP, BLAINE) **Modified on 3/23/2010 to correct "docket text" (laj). (Entered: 03/23/2010)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
3/24/10	3	Summons Issued as to TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY, U.S. Attorney and U.S. Attorney General. (krb) (Entered: 03/24/2010)

DATE	DOCKET NUMBER	PROCEEDINGS
	* * * * *	
5/13/10	41	SUMMONS Returned Executed by STATE OF WASHINGTON, STATE OF ALABAMA, STATE OF SOUTH CAROLINA, STATE OF FLORIDA, STATE OF SOUTH DAKOTA, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF COLORADO, STATE OF IDAHO, STATE OF MICHIGAN, STATE OF TEXAS, COMMONWEALTH OF PENNSYLVANIA, STATE OF UTAH. TIMOTHY F GEITHNER served on 4/12/2010, answer due 5/3/2010; KATHLEEN SEBELIUS served on 3/29/2010, answer due 4/19/2010; HILDA L SOLIS served on 3/29/2010, answer due 5/3/2010; UNITED

DATE	DOCKET NUMBER	PROCEEDINGS
		STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES served on 3/29/2010, answer due 5/3/2010; UNITED STATES DEPARTMENT OF LABOR served on 4/2/2010, answer due 5/3/2010; UNITED STATES DEPARTMENT OF THE TREASURY served on 4/12/2010, answer due 5/3/2010. (Attachments: # 1 Exhibit "A" Return of Service of HHS and H. Solis, # 2 Exhibit "B" Return of Service of Treasury and T. Geithner, # 3 Exhibit "C" Return of Service of Labor and H. Solis, # 4 Exhibit "D" return of Service of Attorney General E. Holder) (WINSHIP, BLAINE) (Entered: 05/13/2010)

DATE	DOCKET NUMBER	PROCEEDINGS
5/14/10	42	First AMENDED COMPLAINT by and through Sonny Perdue, Governor of the State of Georgia, State of Alaska, by and through Daniel S. Sullivan, Attorney General of the State of Alaska, National Federation of Independent Business, a California Nonprofit Mutual Benefit Corporation, State of Nevada, by and through Jim Gibbons, Governor of the State of Nevada, State of North Dakota, by and through Wayne Stenejhem, Attorney General of the State of North Dakota, State of Indiana, by and through Gregory F. Zoeller, Attorney General, State of Mississippi, by and through Haley Barbour, Governor of the State of Mississippi, Kaj Ahlburg, State of Arizona,

DATE	DOCKET NUMBER	PROCEEDINGS
		by and through Janice K. Brewer, Governor of the State of Arizona, Mary Brown, filed by STATE OF WASHINGTON, STATE OF ALABAMA, STATE OF SOUTH CAROLINA, STATE OF FLORIDA, STATE OF SOUTH DAKOTA, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF COLORADO, STATE OF IDAHO, STATE OF MICHIGAN, STATE OF TEXAS, COMMONWEALTH OF PENNSYLVANIA, STATE OF UTAH (WINSHIP, BLAINE) Modified on 5/14/2010 to clean up text (djb). (Entered: 05/14/2010)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
6/16/10	55	**MOTION to Dismiss by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Internal deadline for referral to judge if response not filed earlier: 7/6/2010). (Attachments: # 1 Memorandum in Support) (BECKENHAUER, ERIC) (Entered: 06/16/2010)**
6/17/10	56	**NOTICE *Errata* by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HU-**

DATE	DOCKET NUMBER	PROCEEDINGS
		MAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY re 55 MOTION to Dismiss (Attachments: # 1 Memorandum in Support of 55 Defendants' Motion to Dismiss) (BECKENHAUER, ERIC) (Entered: 06/17/2010)
6/23/10	57	MOTION clarification and leave *(titled as Motion for Clarification of the Court's June 14, 2010 Order and in the Alternative for Leave to Appear as Amicus Curiae and Memorandum in Support)* by States of Oregon, Iowa and Vermont. (DUBANEVICH, KEITH) (Entered: 06/23/2010)

* * * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
8/6/10	68	**RESPONSE in Opposition re 55 MOTION to Dismiss filed by STATE OF FLORIDA, et al (all plaintiffs). (WINSHIP, BLAINE) **Modified on 8/6/2010 to create linkage for filers. (laj). (Entered: 08/06/2010)**

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
8/27/10	74	**REPLY to Response to Motion re 55 MOTION to Dismiss filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY.**

DATE	DOCKET NUMBER	PROCEEDINGS
		(KENNEDY, BRIAN) (Entered: 08/27/2010)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
9/14/10	75	Minute Entry for proceedings held before SENIOR JUDGE ROGER VINSON: Oral Argument as to Defendants' 55 MOTION to Dismiss held on 9/14/2010. (Court Reporter Donna Boland.) (Attachments: # 1 Plaintiffs' Exhibit 1) (jmd) (Entered: 09/15/2010)
9/15/10	76	AMENDED FINAL SCHEDULING ORDER - Re: 26 Order - A) I will enter my written Order on the Dfts' 55 Motion to Dismiss on or before 10/14/2010. Assuming the case survives dismissal in whole or in part, the parties have until 11/4/2010 in which to move

DATE	DOCKET NUMBER	PROCEEDINGS
		for summary judgment (and the Dfts may file their answer at the same time); the opposing party will have until 11/23/2010 to respond; and the moving party will have until 12/6/2010 to file any Reply. B) As provided in the original Final Scheduling Order, the briefing with regard to the motions discussed above will be limited to (50) pages for the initial and responsive briefs, and (25) pages for reply briefs. C) Hearing and oral argument on the motion(s) for summary judgment will held on Thursday, 12/16/2010 @ 9:00 AM (CST). Both sides will be allowed (1) hour for argument. Signed by SENIOR JUDGE ROGER VINSON on 9/15/2010. (laj) (Entered: 09/16/2010)

DATE	DOCKET NUMBER	PROCEEDINGS

* * * * *

10/8/10	78	NOTICE *of Supplemental Authority* by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Exhibit Thomas More Law Center v. Obama, No. 10-CV-11156 (E.D. Mich. Oct. 7, 2010)) (BECKENHAUER, ERIC) (Entered: 10/08/2010)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
10/14/10	79	ORDER AND MEMORANDUM OPINION - The Dfts' 55 Motion to Dismiss is GRANTED w/respect to Counts Two, Five, and Six, and those counts are hereby DISMISSED. The Motion is DENIED w/respect to Counts One and Four, Count Three is also DISMISSED, as Moot. The case will continue as to Counts One and Four pursuant to the Scheduling Order previously entered. Signed by SENIOR JUDGE ROGER VINSON on 10/14/2010. (laj) (Entered: 10/14/2010)

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DATE	DOCKET NUMBER	PROCEEDINGS
11/4/10	80	MOTION for Summary Judgment by PLAINTIFF STATES. (Internal deadline for referral to judge if re-

DATE	DOCKET NUMBER	PROCEEDINGS
		sponse not filed earlier: 11/22/2010). (Attachments: # 1 Memorandum of Law, # 2 Statement of Material Facts, # 3 Exhibits Volume I, # 4 Exhibits Volume II, # 5 Exhibits Volume III, # 6 Exhibits Volume IV) (tdg) (Additional attachment(s) added on 11/4/2010: # 7 Exhibits Volume V.1 (35, 36), # 8 Exhibits Volume V.2 (37,38), # 9 Exhibits Volume V.3 (39,40)) (tdg). (Entered: 11/04/2010)
11/4/10	81	ANSWER to Complaint *42 Amended Complaint* by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT

DATE	DOCKET NUMBER	PROCEEDINGS
		OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) (Entered: 11/04/2010)
11/4/10	82	MOTION for Summary Judgment by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Internal deadline for referral to judge if response not filed earlier: 11/22/2010). (Attachments: # 1 Memorandum in Support, # 2 Statement of Facts) (BECKEN-

DATE	DOCKET NUMBER	PROCEEDINGS
		HAUER, ERIC) (Entered: 11/04/2010)
11/5/10	83	NOTICE *Errata re Exhibits in support of 82 Defendants' Motion for Summary Judgment* by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Table of Exhibits, # 2 Exhibit 1, # 3 Exhibit 2, # 4 Exhibit 3, # 5 Exhibit 4, # 6 Exhibit 5, # 7 Exhibit 6, # 8 Exhibit 7, # 9 Exhibit 8, # 10 Exhibit 9, # 11 Exhibit 10, # 12 Exhibit 11, # 13 Exhibit 12, # 14

DATE	DOCKET NUMBER	PROCEEDINGS
		Exhibit 13, # 15 Exhibit 14, # 16 Exhibit 15, # 17 Exhibit 16, # 18 Exhibit 17, # 19 Exhibit 18, # 20 Exhibit 19, # 21 Exhibit 20, # 22 Exhibit 21, # 23 Exhibit 22, # 24 Exhibit 23, # 25 Exhibit 24, # 26 Exhibit 25, # 27 Exhibit 26, # 28 Exhibit 27, # 29 Exhibit 28, # 30 Exhibit 29, # 31 Exhibit 30, # 32 Exhibit 31, # 33 Exhibit 32, # 34 Exhibit 33, # 35 Exhibit 34, # 36 Exhibit 35, # 37 Exhibit 36, # 38 Exhibit 37, # 39 Exhibit 38, # 40 Exhibit 39, # 41 Exhibit 40, # 42 Exhibit 41, # 43 Exhibit 42, # 44 Exhibit 43) (BECKENHAUER, ERIC) (Entered: 11/05/2010)

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DATE	DOCKET NUMBER	PROCEEDINGS
11/8/10	85	NOTICE *of Filing* by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE

DATE	DOCKET NUMBER	PROCEEDINGS
		OF WASHINGTON (Attachments: # 1 Plaintiffs Statement of Position on Motions for Leave to File Briefs as Amici Curiae) (WINSHIP, BLAINE) (Entered: 11/08/2010)

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DATE	DOCKET NUMBER	PROCEEDINGS
11/16/10	119	**AMICUS CURIAE BRIEF by JOHN A BOEHNER *in support of Plaintiffs' Motion for Summary Judgment*. (SEVERINO, CARRIE) (Entered: 11/16/2010)**
11/17/10	120	**AMICUS CURIAE BRIEF by AMERICAN ASSOCIATION OF PEOPLE WITH DISABILITIES *et al.*. (BOBROFF, ROCHELLE) (Entered: 11/17/2010)**

DATE	DOCKET NUMBER	PROCEEDINGS
11/18/10	121	AMICUS CURIAE BRIEF by UNITED STATES SENATORS *in support of Plaintiffs' Motion for Summary Judgment.* (SEVERINO, CARRIE) (Entered: 11/18/2010)
11/19/10	122	AMICUS CURIAE BRIEF by AMERICAN CENTER FOR LAW AND JUSTICE, *Various Members of Congress, and the Constitutional Committee.* (WHITE, EDWARD) (Entered: 11/19/2010)
11/19/10	123	AMICUS CURIAE BRIEF by FAMILY RESEARCH COUNCIL *Supporting Plaintiffs' Motion for Summary Judgment.* (KLUKOWSKI, KENNETH) (Entered: 11/19/2010)

DATE	DOCKET NUMBER	PROCEEDINGS
11/19/10	124	AMICUS CURIAE BRIEF by American Nurses Association *in support of defendants' motion for summary judgment.* (MILLHISER, IAN) (Entered: 11/19/2010)
11/19/10	125	MEMORANDUM in Support re 82 MOTION for Summary Judgment *Brief Amici Curiae of Economic Scholars in Support of Defendants' Motion for Summary Judgment* filed by David Cutler. (ROSEN, RICHARD) (Entered: 11/19/2010)
11/19/10	126	AMICUS CURIAE BRIEF by STATE LEGISLATORS *in Support of Defendants' Motion for Summary Judgment.* (WYDRA, ELIZABETH) (Entered: 11/19/2010)

DATE	DOCKET NUMBER	PROCEEDINGS
11/19/10	127	AMICUS CURIAE BRIEF by AMERICAN CIVIL RIGHTS UNION (ACRU) *In Support of Plaintiff's Motion for Summary Judgment and in Opposition to Defendant's Motion for Summary Judgment.* (TRAGOS, GEORGE) (Entered: 11/19/2010)
11/19/10	128	AMICUS CURIAE BRIEF by Young Invincibles. (ANNINO, PAOLO) (Entered: 11/19/2010)
11/19/10	129	MEMORANDUM in Support re 82 MOTION for Summary Judgment *Brief Amicus Curiae* filed by SMALL BUSINESS MAJORITY FOUNDATION. (SANDLER, JOSEPH) (Entered: 11/19/2010)

DATE	DOCKET NUMBER	PROCEEDINGS
11/19/10	130	AMICUS CURIAE BRIEF by STATES OF OREGON, IOWA, AND VERMONT. (DUBANEVICH, KEITH) (Entered: 11/19/2010)
11/19/10	131	AMICUS CURIAE BRIEF by American Hospital Association et al. *in support of Defendants.* (STETSON, CATHERINE) (Entered: 11/19/2010)
11/19/10	132	AMICUS CURIAE BRIEF by Governor Tim Pawlenty re 80 MOTION for Summary Judgment. (BADER, HANS) (Entered: 11/19/2010)
11/19/10	133	AMICUS CURIAE BRIEF by GOVERNORS OF COLORADO, MICHIGAN, PENNSYLVANIA AND WASHINGTON IN SUPPORT OF DEFENDANTS'

DATE	DOCKET NUMBER	PROCEEDINGS
		MOTION FOR SUMMARY JUDGMENT. (BARAUSKAS, ALEKSAS) (Entered: 11/19/2010)
11/19/10	134	AMICUS CURIAE BRIEF by AMERICAN ACADEMY OF PEDIATRICS *In Support of Defendants' Motion for Summary Judgment.* (SOMERS, SARAH) (Entered: 11/19/2010)
11/23/10	135	PLAINTIFFS MEMORANDUM in Opposition to Defendants' Motion for Summary Judgment 82 filed by STATE OF FLORIDA. (Attachments: # 1 Supplemental Appendix) (tdg) (Entered: 11/23/2010)
11/23/10	136	PLAINTIFFS' RESPONSE to Defendants' Statement of Facts As to Which There Is No Genuine Issue 82 filed by

DATE	DOCKET NUMBER	PROCEEDINGS
		STATE OF FLORIDA. (tdg) (Entered: 11/23/2010)
11/23/10	137	MEMORANDUM in Opposition re 80 MOTION for Summary Judgment filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Attachments: # 1 Response to Plaintiffs' Statement of Facts) (BECKENHAUER, ERIC) (Entered: 11/23/2010)
12/2/10	140	MOTION for Leave to File Amicus Curiae Brief by pro se litigant W. Spencer Connerat, III. (laj) (Entered: 12/07/2010)

DATE	DOCKET NUMBER	PROCEEDINGS
12/6/10	138	REPLY to Response to Motion re 80 MOTION for Summary Judgment filed by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DA-

DATE	DOCKET NUMBER	PROCEEDINGS
		KOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON. (WINSHIP, BLAINE) (Entered: 12/06/2010)
12/6/10	139	REPLY to Response to Motion re 82 MOTION for Summary Judgment filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) (Entered: 12/06/2010)

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DATE	DOCKET NUMBER	PROCEEDINGS
12/14/10	143	NOTICE of *Supplemental Authority* by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF

DATE	DOCKET NUMBER	PROCEEDINGS
		UTAH, STATE OF WASHINGTON (Attachments: # 1 Exhibit Virginia Order Granting Summary Judgment) (WINSHIP, BLAINE) (Entered: 12/14/2010)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
12/16/10	145	Minute Entry for proceedings held before SENIOR JUDGE ROGER VINSON: oral arguments as to parties' motions for summary judgment held on 12/16/2010. (Court Reporter Donna Boland.) (jmd) (Entered: 12/16/2010)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
1/18/11	147	MOTION for Leave to File *Second Amended Complaint* by KAJ AHLBURG, MARY BROWN, COMMON

DATE	DOCKET NUMBER	PROCEEDINGS
		WEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON. (WINSHIP, BLAINE) (Entered: 01/18/2011)

DATE	DOCKET NUMBER	PROCEEDINGS
1/18/11	148	Second **AMENDED COMPLAINT** against **TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY**, filed by **STATE OF NORTH DAKOTA, STATE OF ALABAMA, STATE OF ALASKA, COMMONWEALTH OF PENNSYLVANIA, STATE OF WASHINGTON, STATE OF INDIANA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF MISSISSIPPI, STATE OF GEORGIA, STATE OF IDAHO, STATE OF NE-**

DATE	DOCKET NUMBER	PROCEEDINGS
		VADA, STATE OF SOUTH CAROLINA, STATE OF FLORIDA, MARY BROWN, KAJ AHLBURG, STATE OF SOUTH DAKOTA, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF MICHIGAN, STATE OF TEXAS, STATE OF UTAH. (WINSHIP, BLAINE) (Entered: 01/18/2011)
1/19/11	149	ORDER - The plaintiffs' motion for leave to file a second amended complaint (doc. 147) is hereby GRANTED, and the new complaint will be deemed filed as of this date, as will the defendants' previously-filed answer. Signed by SENIOR JUDGE ROGER VINSON on

DATE	DOCKET NUMBER	PROCEEDINGS
		1/19/2011. (djb) (Entered: 01/19/2011)
1/31/11	150	ORDER GRANTING SUMMARY JUDGMENT - For all the reasons stated and pursuant to Rule 56 of the Federal Rules of Civil Procedure, the plaintiffs motion for summary judgment (doc. 80) is hereby GRANTED as to its request for declaratory relief on Count I of the Second Amended Complaint, and DENIED as to its request for injunctive relief; and the defendants' motion for summary judgment (doc. 82) is hereby GRANTED on Count IV of the Second Amended Complaint. The respective cross-motions are each DENIED. In accordance with Rule 57 of the Federal Rules of Civil Proce-

DATE	DOCKET NUMBER	PROCEEDINGS
		dure and Title 28, United States Code, Section 2201(a), a Declaratory Judgment shall be entered separately, declaring "The Patient Protection and Affordable Care Act" unconstitutional. Signed by SENIOR JUDGE ROGER VINSON on 1/31/2011. (djb) Modified on 1/31/2011 (djb). (Entered: 01/31/2011)
1/31/11	151	FINAL SUMMARY DECLARATORY JUDGMENT. It is hereby DECLARED, ADJUDGED, and DECREED that The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124

DATE	DOCKET NUMBER	PROCEEDINGS
		Stat. 1029 (2010), is unconstitutional. Signed by SENIOR JUDGE ROGER VINSON on 1/31/2011. (djb) (Entered: 01/31/2011)

* * * * *

2/17/11	156	MOTION To Clarify re 150 Order on Motion for Summary Judgment,,,,,,, 151 Judgment, by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) (Entered: 02/17/2011)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
2/18/11	157	**ORDER DIRECTING EXPEDITED FILING re 156 MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment. From the date of this Order, the plaintiffs shall have 3 business days in which to file their response in opposition to the defendants' motion. If the defendants wish to file a reply to that response, they shall also have 3 business days from the date the response is filed. (Internal deadline for referral to judge if response not filed on: 2/23/2011.) Signed by SENIOR JUDGE ROGER VINSON on February 18, 2011. (tl) Modified on 2/22/2011 to clarify text. (tl)** (Entered: 02/18/2011)

DATE	DOCKET NUMBER	PROCEEDINGS
2/23/11	158	**MEMORANDUM** in Opposition re 156 **MOTION** To Clarify re 150 **Order** on Motion for Summary Judgment, 151 Judgment, filed by KAJ AHLBURG, TERRY E BRANSTAD, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF KANSAS, STATE OF LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NE-

DATE	DOCKET NUMBER	PROCEEDINGS
		BRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF WYOMING. (WINSHIP, BLAINE) Modified on 2/24/2011 to clarify text (tl). (Entered: 02/23/2011)

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DATE	DOCKET NUMBER	PROCEEDINGS
2/28/11	164	REPLY to 158 Response to 156 MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment, filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED

DATE	DOCKET NUMBER	PROCEEDINGS
		STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) Modified on 3/1/2011 to clarify text, create link. (tl) (Entered: 02/28/2011)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
3/3/11	167	ORDER. The defendants' motion to clarify 156 is GRANTED. To the extent that motion is construed as a motion to stay, it is also GRANTED, and the summary declaratory judgment entered in this case is STAYED pending appeal, conditioned upon the defendants filing their notice of

DATE	DOCKET NUMBER	PROCEEDINGS
		appeal within seven (7) calendar days of this order and seeking an expedited appellate review. Signed by SENIOR JUDGE ROGER VINSON on 3/3/11. (tdg) (Entered: 03/03/2011)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
3/8/11	169	NOTICE OF APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary Judgment,,,,,,, 151 Judgment, 167 Order, by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY.

DATE	DOCKET NUMBER	PROCEEDINGS
		((BECKENHAUER, ERIC) (Entered: 03/08/2011)

* * * * *

3/10/11	173	NOTICE OF CROSS APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary Judgment,,,,,,, 151 Judgment, by KAJ AHLBURG, TERRY E BRANSTAD, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF

DATE	DOCKET NUMBER	PROCEEDINGS
		KANSAS, STATE OF LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF WYOMING. Filing fee $ 455, receipt number 1129-1831078. Appeal Record due by 3/8/2011. (WINSHIP, BLAINE) (Entered: 03/10/2011)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
3/11/11	177	USCA Case Number 11-11021-HH for 169 NOTICE OF APPEAL by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (tl) (Entered: 03/11/2011)

* * * * *

DATE	DOCKET NUMBER	PROCEEDINGS
3/11/11	179	AMENDED NOTICE OF CROSS APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary Judgment,,,,,,, 151 Judgment, by KAJ AHLBURG, TERRY E BRANSTAD, MARY

DATE	DOCKET NUMBER	PROCEEDINGS
		BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF KANSAS, STATE OF LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF

DATE	DOCKET NUMBER	PROCEEDINGS
		UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF WYOMING. Appeal Record due by **3/8/2011**. (WINSHIP, BLAINE) Modified on 3/14/2011 to clarify text. (tl) (Entered: 03/11/2011)

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DATE	DOCKET NUMBER	PROCEEDINGS
4/4/11	192	ORDER of USCA as to 169 Notice of Appeal #11-11021-HH, 173 Notice of Cross Appeal #11-11067-HH: Petition for Initial Hearing En Banc is Denied. Motion to expedite this appeal is Granted in part. Oral argument shall be heard on Wednesday, June 8, 2011, at 9:30 A.M. in Atlanta, GA. (tll) (Entered: 04/08/2011)

DATE	DOCKET NUMBER	PROCEEDINGS
		* * * * *
10/25/11	196	**MANDATE of USCA AFFIRMING in part and REVERSING in part 169 Notice of Appeal and 173 Notice of Cross Appeal. (USCA Appeal #'s 11-11021-HH; 11-11067-HH) (kvg) (Entered: 10/25/2011)**

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Pensacola Division

Case No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL
MCCOLLUM, ATTORNEY GENERAL OF THE STATE OF
FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES, ET AL., RESPONDENTS

Filed: May 14, 2010

AMENDED COMPLAINT

Pursuant to Rule 15(a), Federal Rules of Civil Procedure, and paragraph A of the Final Scheduling Order entered by the Court on April 14, 2010, Plaintiffs file this Amended Complaint against Defendants and state:

NATURE OF THE ACTION

1. This is an action seeking declaratory and injunctive relief from the "Patient Protection and Affordable Care Act," P.L. 111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," P.L. 111-152 (collectively the Act). The Act's mandate that all citizens and legal residents of the United States

maintain qualifying healthcare coverage or pay a penalty (individual mandate) is an unprecedented encroachment on the sovereignty of the Plaintiff States and on the rights of their citizens, including members of Plaintiff National Federation of Independent Business (NFIB) and individual Plaintiffs Mary Brown and Kaj Ahlburg. By imposing such a mandate, the Act: exceeds the powers of the United States under Article I of the Constitution, particularly the Commerce Clause; violates the Ninth and Tenth Amendments and the Constitution's principles of federalism and dual sovereignty; and violates the Fifth Amendment's Due Process Clause. In the alternative, if the penalty required under the Act is a tax, it constitutes an unlawful capitation or direct tax in violation of Article I, sections 2 and 9 of the Constitution.

2. The Act further violates the Constitution by forcing the Plaintiff States to operate a wholly refashioned Medicaid program. The Act converts Medicaid from a federal-State partnership to provide a safety net for the needy into a federally-imposed universal healthcare regime, in which the discretion of the Plaintiff States has been removed and new requirements and expenses forced upon them in derogation of their sovereignty. In so doing, the Act violates the Ninth and Tenth Amendments and the Constitution's principles of federalism.

3. Plaintiffs seek declaratory and injunctive relief against the Act's operation in order to avoid an unprecedented and unconstitutional intrusion by the federal government into the private affairs of every American and to preserve Plaintiff States' respective sovereignty, as guaranteed by the Constitution.

JURISDICTION AND VENUE

4. The Court has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331 because this action arises under the Constitution and laws of the United States and further has jurisdiction to render declaratory relief under 28 U.S.C. § 2201.

5. Venue is proper in this district pursuant to 28 U.S.C. § 1391(e)(3) because no real property is involved, the district is situated in Florida, and the defendants are agencies of the United States or officers thereof acting in their official capacity.

PARTIES

6. The State of Florida, by and through Bill McCollum, Attorney General of Florida, is a sovereign State in the United States of America.

7. The State of South Carolina, by and through Henry McMaster, Attorney General of South Carolina, is a sovereign State in the United States of America.

8. The State of Nebraska, by and through Jon Bruning, Attorney General of Nebraska, is a sovereign State in the United States of America.

9. The State of Texas, by and through Greg Abbott, Attorney General of Texas, is a sovereign State in the United States of America.

10. The State of Utah, by and through Mark L. Shurtleff, Attorney General of Utah, is a sovereign State in the United States of America.

11. The State of Alabama, by and through Troy King, Attorney General of Alabama, is a sovereign State in the United States of America.

12. The State of Louisiana, by and through James D. "Buddy" Caldwell, Attorney General of Louisiana, is a sovereign State in the United States of America.

13. Michael A. Cox, Attorney General of Michigan, is bringing this action on behalf of the People of Michigan under Mich. Comp. Law § 14.28, which provides that the Michigan Attorney General may "appear for the people of [Michigan] in any other court or tribunal, in any cause or matter, civil or criminal, in which the people of [Michigan] may be a party or interested." Under Michigan's constitution, the people are sovereign. Mich. Const. art. I, § 1 ("All political power is inherent in the people. Government is instituted for their equal benefit, security,. and protection.").

14. The State of Colorado, by and through John W. Suthers, Attorney General of Colorado, is a sovereign State in the United States of America.

15. The Commonwealth of Pennsylvania, by and through Thomas W. Corbett, Jr., Attorney General of Pennsylvania, is a sovereign State in the United States of America.

16. The State of Washington, by and through Robert A. McKenna, Attorney General of Washington, is a sovereign State in the United States of America.

17. The State of Idaho, by and through Lawrence G. Wasden, Attorney General of Idaho, is a sovereign State in the United States of America.

18. The State of South Dakota, by and through Marty J. Jackley, Attorney General of South Dakota, is a sovereign State in the United States of America.

19. The State of Indiana, by and through Gregory F. Zoeller, Attorney General of Indiana, is a sovereign State in the United States of America.

20. The State of North Dakota, by and through Wayne Stenehjem, Attorney General of North Dakota, is a sovereign State in the United States of America.

21. The State of Mississippi, by and through Haley Barbour, Governor of Mississippi, is a sovereign State in the United States of America.

22. The State of Arizona, by and through Janice K. Brewer, Governor of Arizona, is a sovereign State in the United States of America.

23. The State of Nevada, by and through Jim Gibbons, Governor of Nevada, is a sovereign State in the United States of America.

24. The State of Georgia, by and through Sonny Perdue, Governor of Georgia, is a sovereign State in the United States of America.

25. The State of Alaska, by and through Daniel S. Sullivan, Attorney General of Alaska, is a sovereign State in the United States of America.

26. The National Federation of Independent Business (NFIB), a California nonprofit mutual benefit corporation, is the nation's leading association of small businesses, including individual members, and has a presence in all 50 States and the District of Columbia. NFIB's mission is to promote and protect the rights of its members to own, operate, and earn success in their businesses, in accordance with lawfully-imposed governmental requirements. The NFIB Small Business Legal Center is a nonprofit, public interest law firm estab-

lished to provide legal resources and be the voice for small businesses in the nation's courts through representation on issues of public interest affecting small businesses. NFIB's members include individuals who object to: forced compliance with the Act's mandate that they obtain qualifying healthcare insurance or pay a penalty; diversion of resources from their businesses that will result from complying with the mandate; and the Act's overreaching and unconstitutional encroachment on the States' sovereignty. NFIB joins in those objections on behalf of its members. NFIB's services to its members include providing information regarding legal and regulatory issues faced by small businesses, including individuals. NFIB will incur additional costs in assisting its members in understanding how the Act applies to them and affects their businesses.

27. Mary Brown is a citizen and resident of the State of Florida and a citizen of the United States. She is self-employed, operating Brown & Dockery, Inc., an automobile repair facility in Panama City, Florida, and is a member of NFIB. Ms. Brown has not had healthcare insurance for the last four years, and devotes her resources to maintaining her business and paying her employees. She does not qualify for Medicaid under the Act or Medicare and does not expect to qualify for them prior to the Act's individual mandate taking effect. Ms. Brown will be subject to the mandate and objects to being forced to comply with it, and objects to the Act's unconstitutional overreaching and its encroachment on the States' sovereignty.

28. Kaj Ahlburg is a citizen and resident of the State of Washington and a citizen of the United States. Mr. Ahlburg has not had healthcare insurance for more than

six years, does not have healthcare insurance now, and has no intention or desire to have healthcare insurance in the future. Mr. Ahlburg is and reasonably expects to remain financially able to pay for his own healthcare services if and as needed. He does not qualify for Medicaid under the Act or Medicare and does not expect to qualify for them prior to the Act's individual mandate taking effect. Mr. Ahlburg will be subject to the mandate and objects to being forced to comply with it, and objects to the Act's unconstitutional overreaching and its encroachment on the States' sovereignty. (Plaintiffs Brown and Ahlburg are referred to as the Individual Plaintiffs.)

29. The Department of Health and Human Services (HHS) is an agency of the United States, and is responsible for administration and enforcement of the Act, through its center for Medicare and Medicaid Services.

30. Kathleen Sebelius is Secretary of HHS, and is named as a party in her official capacity.

31. The Department of the Treasury (Treasury) is an agency of the United States, and is responsible for administration and enforcement of the Act.

32. Timothy F. Geithner is Secretary of the Treasury, and is named as a party in his official capacity.

33. The Department of Labor (DOL) is an agency of the United States, and is responsible for administration and enforcement of the Act.

34. Hilda L. Solis is Secretary of DOL, and is named as a party in her official capacity.

FACTUAL ALLEGATIONS

The Unprecedented and Unconstitutional Individual Mandate

35. The Act mandates that all persons who are citizens or legal residents of any State within the United States, including NFIB members and the Individual Plaintiffs, must have and maintain qualifying healthcare coverage, regardless of whether they wish to do so, to avoid having to pay a penalty. Many individuals, including NFIB members and the Individual Plaintiffs, will be forced to purchase the required coverage with their own assets, without contribution or subsidy from the federal government. If a person fails to maintain such coverage, the federal government will force that person to pay a penalty, the amount of which will be increased gradually through 2016, reaching 2.5 percent of household income or $695 per year (up to a maximum of three times that amount ($2,085)) per family, whichever is greater. After 2016, the penalty will increase annually based on a cost-of-living adjustment.

36. Exemptions to the penalty apply for individuals with certain religious objections, individuals who belong to certain faith-based healthcare cooperative organizations, American Indians, persons without coverage for less than three months, undocumented immigrants, incarcerated individuals, persons for whom the lowest cost plan option exceeds 8 percent of income, individuals with incomes below the tax filing threshold, and persons with financial hardships. Millions of individuals will be forced to choose between having qualified coverage and paying the penalty.

37. Congress never before has imposed a mandate that all citizens buy something—in this case health

insurance—or pay a penalty. According to the nonpartisan Congressional Budget Office (CBO), "the imposition of an individual mandate [to buy health insurance] . . . would be unprecedented. The government has never required people to buy any good or service as a condition of lawful residence in the United States." THE BUDGETARY TREATMENT OF AN INDIVIDUAL MANDATE TO BUY HEALTH INSURANCE, CBO MEMORANDUM (August 1994), http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf (last visited May 11, 2010). The CBO added that an individual mandate could "transform the purchase of health insurance from an essentially voluntary private transaction into a compulsory activity mandated by law." Id.

38. Congress lacks the constitutional authority to enact the individual mandate. The Constitution limits Congress's authority to the specific powers enumerated in Article I, and thus does not grant unlimited authority to Congress. None of Congress's enumerated powers includes the authority to force every American to buy a good or service on the private market or face a penalty. For the first time, Congress under the Act is attempting to regulate and penalize Americans for choosing not to engage in economic activity. If Congress can do this much, there will be virtually no sphere of private decision-making beyond the reach of federal power.

Medicaid Program Prior to the Act

39. Medicaid was established by Title XIX of the Social Security Act of 1965, 42 U.S.C. §§ 1396 et seq., as the nation's major healthcare program for low-income persons. The States and the federal government have funded each participating State's Medicaid program jointly.

40. From the beginning of Medicaid until passage of the Act, the States were given considerable discretion to implement and operate their respective Medicaid programs in accordance with State-specific designs regarding eligibility, enrollment, and administration, so long as the programs met broad federal requirements.

41. At the outset of Medicaid, the States were free to opt in and establish their own State health or welfare plans or to provide no benefits at all. None of the Plaintiff States agreed to become a Medicaid partner of the federal government with an expectation that: a) the terms of its participation would be altered significantly; b) the federal government would increase significantly its own control and reduce significantly that State's discretion over the Medicaid program; c) the federal government would alter the program's requirements to expand eligibility for enrollment beyond the State's ability to fund its participation; d) the federal government would alter the program from requiring that States pay for healthcare services to requiring that States provide such services; or e) the federal government would exercise its control over Medicaid terms and eligibility as part of a coercive scheme to force all citizens and residents of the States to have healthcare coverage.

The Act's Injurious Impact on the Federal-State Healthcare Partnership

42. The Act greatly alters the federal-State relationship, to the detriment of the Plaintiff States, with respect to Medicaid programs, their insurance regulatory role, and healthcare coverage generally.

43. The Act transforms Medicaid from federal-State partnerships into a broad federally-controlled program that deprives the States of the ability to define health-

care program eligibility and attributes, and eliminates States' historic flexibility to make cost-saving and other adjustments to their respective Medicaid programs. The Act also sets new increased Medicaid rates for primary-care practitioners' reimbursements, which States must substantially fund, and changes the manner in which drug rebates are allocated between the federal government and States in a manner that financially benefits the federal government at the States' expense.

44. The Act requires each State to expand massively its Medicaid program and to create a statewide exchange, which must be either a State governmental agency or a nonprofit entity established by the State for this purpose, through which the citizens and residents of that State can purchase healthcare insurance. If a State does not satisfy federal requirements to progress toward creation of an intrastate insurance exchange between now and the end of 2012, or chooses not to operate an exchange, the federal government (or its contractor) will establish and administer an intrastate exchange within that State. This action would displace State authority over a substantial segment of intrastate insurance regulation (e.g., licensing and regulation of intrastate insurers, plans, quality ratings, coordination with Medicaid and other State programs, and marketing) that the States have always possessed under the police powers provided in the Constitution, and subject the States to possible exchange-related penalties.

45. Participation in the Act will force the States to expand their Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level. The federal government will fund much of the cost initially, but States' coverage burdens

will increase significantly after 2016, both in actual dollars and in proportion to the contributions of the federal government.

46. The Act further requires that States provide healthcare services to enrollees, a significant new obligation that goes far beyond the States' pre-Act responsibility for funding healthcare services under their respective Medicaid programs. This obligation will expose the States to significant increased litigation risks and costs.

47. The federal government will not provide full funding or resources to the States to administer the Act. Each State must oversee the newly-created intrastate insurance market by instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes. Each State also must enroll all of the newly-eligible Medicaid beneficiaries (many of whom will be subject to a penalty if they fail to enroll), coordinate enrollment with the new intrastate insurance exchange, and implement other specified changes. The Act further requires each State to establish a reinsurance program by 2014, to administer a premium review process, and to cover costs associated with State-mandated insurance benefit requirements that States previously could impose without assuming a cost.

48. In addition, the Act imposes new requirements on the Plaintiff States that interfere with their ability to perform governmental functions. Effective in 2014, the Plaintiff States, as large employers, must automatically enroll employees working 30 or more hours a week into health insurance plans, without regard for current State practice, policy preferences, or financial constraints. The Act's individual mandate effectively will force many more State employees into State insurance plans than

the Plaintiff States now allow, at a significant added cost to the States. Moreover, the States will be subject to substantial penalties and taxes prescribed by the Act, at a cost of thousands of dollars per employee, for State employees who obtain subsidized insurance from an exchange instead of from a State plan, or if the State plan offers coverage that is either too little or too generous as determined by the federal government. New tax reporting requirements prescribed by the Act also will burden the Plaintiff States' ability to source goods and services as necessary to carry out governmental functions.

The Act's Injurious Impact on Plaintiffs

49. The Act will have a profound and injurious impact on all Plaintiff States. Florida's circumstances, as described below, are not identical to the circumstances in all of the Plaintiff States, but fairly represent the nature of the burdens the Act imposes on the Plaintiff States.

50. Based on United States Census Bureau statistics from 2008, Florida has 3,641,933 uninsured persons living in the State. Of those persons, 1,259,378 are below 133 percent of the federal poverty line; therefore, the Act requires that Florida add them to its Medicaid rolls.

51. Even before passage of the Act, the Medicaid program imposed a heavy cost on Florida, consuming 26 percent of its annual budget. For fiscal year 2009-2010 alone, Florida will spend more than $18 billion on Medicaid, servicing more than 2.7 million persons. Florida's Medicaid contributions and burdens, from the implementation of its Medicaid program in 1970 to the present, have gradually increased to the point where it would be infeasible for Florida to cease its participation in

Medicaid before the Act takes effect and make alternate arrangements for a traditional Medicaid-like program.

52. The federal government currently contributes 67.64 percent of every dollar Florida spends on Medicaid, a percentage that is temporarily inflated because of federal stimulus outlays. Under the current pre-Act program, after this year, the percentage of Florida's Medicaid expenses covered by the federal government would decline, and by 2011 would reach 55.45 percent, a level that is closer to the recent average. The federal government's contribution under the Act, though providing more aid for newly-eligible persons, will not fully compensate Florida for the dramatic increase to its Medicaid rolls, increased reimbursement rates for primary-care practitioners, and other substantial costs that it must bear under the Act.

53. Florida's Agency for Health Care Administration (AHCA) estimates that at least 80 percent of persons who have some form of health insurance but fall below 133 percent of the federal poverty level will drop their current plans and enroll in Medicaid, because they are newly eligible under the Act. The Act does not provide full funding for the States' cost of covering these already-covered persons. These persons represent a significant additional cost to Florida under the Act.

54. The Act also makes a large new class of persons eligible for Medicaid in Florida. Prior to passage of the Act, only certain specified low-income individuals and families qualified for Medicaid. Moreover, the qualifying income level set by Florida was generally much lower than the level of 133 percent of the federal poverty line set by the federal government under the Act. Now, Florida also must add to its Medicaid rolls every child-

less adult whose income falls below 133 percent of the federal poverty line, consistent with the Act's fundamental change in Medicaid from a federal-State partnership to provide a safety net for the needy into a federally-imposed regime for universal healthcare coverage.

55. Prior to passage of the Act, AHCA was Florida's designated State Medicaid agency tasked with developing and carrying out policies related to the Medicaid program. The Act will strip away much of the State's authority to establish and execute policies, transferring that authority to the federal government. Indeed, the Act renders AHCA and other Florida agencies mere arms of the federal government and commandeers and forces AHCA employees to administer what now is essentially a federal universal healthcare program.

56. AHCA projects a cost to Florida in the billions of dollars between now and 2019, stemming from Medicaid-related portions of the Act. The annual cost will continue to grow in succeeding years. AHCA's projections, moreover, understate the Act's adverse impact on Florida. They do not include estimated costs to be borne by Florida to administer the Act or to prepare for the Act's implementation. Such costs will include hiring and training new staff, creating new information technology infrastructures, developing an adequate provider base, creating a scheme for accountability and quality assurance, and incurring many other expenses.

57. The Act requires that Florida immediately begin to devote funds and other resources to implement sweeping changes across multiple agencies of government. Such implementation burdens include, but are not limited to: a) enforcing the Act's immediately-effective terms; b) determining gaps between current resources

in State government and the Act's requirements; c) evaluating infrastructure to consider how new programs and substantial expansion of existing programs will be implemented (e.g., new agencies, offices, etc.); d) developing a strategic plan and coordinating common issues across State agencies; e) initiating legislative and regulatory processes, while at the same time monitoring and engaging the substantial federal regulatory processes to ensure that State interests are protected; f) electing whether to participate in optional programs set forth in the Act; g) satisfying the Act's interim targets; and h) developing a communications structure and plan to disseminate new information regarding changes brought about by the Act to the many affected persons and entities.

58. The Act further requires Florida to enroll in healthcare insurance plans categories of State employees not previously covered by State-funded healthcare insurance plans. The Act subjects the State to penalties, depending upon the coverage decisions made by its employees, and limits the State's ability to determine coverage. If the State's plan for its employees is deemed inadequate by the federal government, the State will be subject to penalties. If the State's plan is deemed too generous or expansive by the federal government, the State will be subject to a distinct federal tax liability.

59. The Act also requires that Florida be responsible for providing healthcare services for all Medicaid enrollees in the expanded program, a significant change from Florida's responsibility for providing payment for such services. This added responsibility and resulting new legal liabilities further contribute to the Act's substantial and costly impact on Florida's fisc, and will

force the State to ignore other critical needs, including education, corrections, law enforcement, and more.

60. In sum, as demonstrated through the effects on Florida, the Act infringes on the Plaintiff States' constitutional status as sovereigns, entitled to cooperate with but not to be controlled by the federal government under the Medicaid program.

61. In addition, the Act will have a profound and injurious impact on the Plaintiff States' citizens and residents, a significant number of whom are or will be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty.

62. The Act further will have a profound and injurious impact on NFIB's individual members and its uninsured small business owners, including Ms. Brown, who are and will continue to be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty. Because of the mandate, these members will be forced to divert resources from their business endeavors, or otherwise to reorder their economic circumstances, in order to obtain qualifying healthcare coverage, regardless of their own conclusions on whether or not obtaining and maintaining such coverage for themselves and their dependents is a worthwhile cost of doing business. The added costs of the mandate will threaten the members' ability to maintain their own, independent businesses.

63. An important service offered by NFIB to its membership is the provision of information and assistance regarding legal and regulatory compliance issues faced by small businesses, as well as questions involving healthcare insurance and benefits. In order fully to serve the needs and interests of its membership, NFIB

now will be forced to devote its own scarce resources to assisting members in understanding how the Act, including the mandate to obtain qualifying coverage or pay a penalty, applies to them, how it will affect their businesses, and what they must do to comply.

64. The Act also will injure Mr. Ahlburg, who will be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty.

The Act's Requirements and Effects on the Plaintiff States Cannot Be Avoided

65. Plaintiff States cannot avoid the Act's requirements. Neither the Act nor current federal Medicaid provisions prescribe a mechanism for a State to opt out of the Act's new Medicaid requirements, to opt out of Medicaid generally, or to transition to another program that provides only traditional Medicaid services.

66. Moreover, if they were to end their longstanding participation in Medicaid, Plaintiff States would desert millions of their residents, leaving them without access to the healthcare services they have depended on for decades under Medicaid. Thus, Plaintiff States are forced to accept the harmful effects of the Act on their fiscs and their sovereignty.

67. Prior to passage of the Act, Medicaid and its corresponding law, regulations, guidance, policies, and framework had been well-established, subject to occasional limited modifications, for more than four decades. During that time, participating States developed their respective Medicaid programs in reliance on Medicaid continuing to be a partnership with the federal government.

68. Presently, the Centers for Medicare and Medicaid (CMS), the federal agency with chief responsibility for administering Medicaid for the federal government, will terminate a State's federal funding for Medicaid unless the State complies with the Act's requirements. In addition, Medicaid requirements are linked to other federal programs, and the benefits of those programs to a State and its citizens and residents would be in jeopardy if the federal government were to terminate the State's participation in Medicaid.

CAUSES OF ACTION

COUNT ONE

UNCONSTITUTIONAL MANDATE THAT ALL INDIVIDUALS HAVE HEALTHCARE INSURANCE COVERAGE OR PAY A PENALTY

(Const. art. I & amend. IX, X)

69. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

70. The Act forces all Americans, including NFIB members and the Individual Plaintiffs, regardless of whether they want healthcare coverage, to obtain and maintain a federally-approved level of coverage or pay a penalty. The Act thus compels all Americans to perform an affirmative act or incur a penalty, simply on the basis that they exist and reside within any of the United States. In so doing, the Act purports to exercise the very type of general police power the Constitution reserves to the States and denies to the federal government.

71. The Act is directed to a lack of, or failure to engage in, activity that is driven by the choices of individual Americans. Such inactivity by its nature cannot be deemed to be in commerce or to have such an effect on commerce, whether interstate or otherwise, as to be subject to Congress's powers under the Commerce Clause, Const. art. I, § 8. Nor does the Act regulate (directly or indirectly) any properly regulable interstate or foreign market or other commerce, any instrumentality of interstate or foreign commerce, or the actual flow of goods, services, and human beings among the States. As a result, the Act cannot be upheld under the Commerce Clause.

72. The Act infringes upon Plaintiff States' sovereign interests by coercing many persons to enroll in an expanded Medicaid program at a substantial cost to Plaintiff States, or to obtain coverage from intrastate exchanges that States must establish to avoid loss of substantial regulatory authority. The Act also denies Plaintiff States their sovereign ability to confer rights upon their citizens and residents to make healthcare decisions without government interference, including the decision not to participate in any healthcare insurance program or scheme, in violation of the Ninth and Tenth Amendments to the Constitution and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

73. The Act's penalty on uninsured persons unlawfully coerces persons to obtain healthcare coverage without purposing to raise revenue and injures the Plaintiff States' fiscs, because many persons will be compelled to enroll in Medicaid at a substantial cost to Plaintiff States or to get coverage from intrastate exchanges that

Plaintiff States must establish to avoid loss of substantial regulatory authority. As a result, the Act cannot be upheld under the Taxing and Spending Clause, Const. art. I, § 8.

74. By requiring and coercing citizens and residents of the Plaintiff States to have healthcare coverage, the Act exceeds Congress's limited powers enumerated in Article I of the Constitution, and cannot be upheld under any other provision of the Constitution.

75. By requiring and coercing citizens and residents of the Plaintiff States to have healthcare coverage, the Act deprives those citizens and residents, and NFIB members and the Individual Plaintiffs, of their rights under State law to make personal healthcare decisions without governmental interference, and violates the rights of the States as sovereigns to confer and define such rights in their constitutions or by statute, in violation of the Ninth and Tenth Amendments to the Constitution and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the individual mandate exceeds Congress's authority under Article I of the Constitution and violates the Ninth and Tenth Amendments;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, including their agencies, officials, and employees; the citizens and residents of the Plaintiff States; NFIB members and small business owners; and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT TWO

UNCONSTITUTIONAL MANDATE THAT ALL INDIVIDUALS HAVE HEALTHCARE INSURANCE COVERAGE OR PAY A PENALTY

(Const. amend. V)

76. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

77. The Act forces citizens and residents of the Plaintiff States, including NFIB members and the Individual Plaintiffs, to obtain and maintain a federally-approved level of health coverage for themselves and their dependents, regardless of whether they want or need that coverage, or pay a penalty.

78. By requiring and coercing NFIB's members and the Individual Plaintiffs to obtain and maintain such healthcare coverage, the Act deprives them of their right to be free of unwarranted and unlawful federal government compulsion in violation of the Due Process Clause of the Fifth Amendment to the Constitution of the United States.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare Defendants to have violated the rights of NFIB members and small business owners and the Individual Plaintiffs under the Due Process Clause of the Fifth Amendment;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against NFIB members and small business owners and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award NFIB and the Individual Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT THREE

VIOLATION OF CONSTITUTIONAL PROHIBITION OF UNAPPORTIONED CAPITATION OR DIRECT TAX

(Const. art. I, §§ 2, 9 & amends. IX, X)

79. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

80. Alternatively, the penalty on uninsured persons under the Act constitutes a capitation and a direct tax that is not apportioned among the States according to census data, thereby injuring the sovereign interests of Plaintiff States and the interests of all citizens and residents of the Plaintiff States and of the United States.

81. The tax applies without regard to property, profession, or any other circumstance, and is unrelated to any taxable event or activity. It is to be levied upon per-

sons for their failure or refusal to do anything other than to exist and reside in any of the States comprising the United States.

82. The tax violates article I, sections 2 and 9 of, and the Ninth and Tenth Amendments to, the Constitution. The Act's imposition of the tax, and the resulting coercion of many persons either to enroll in an expanded Medicaid program at a substantial cost to the Plaintiff States or to get coverage from intrastate exchanges that States must establish to avoid loss of substantial regulatory authority, injures Plaintiff States' sovereign interests and violates the States' constitutional protection against unapportioned capitation taxes or direct taxation. The tax also infringes on the right of NFIB members and the Individual Plaintiffs to be free from unconstitutional taxation. The tax is unconstitutional on its face and cannot be applied constitutionally.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare Defendants to have violated the Plaintiff States' constitutional protection against unapportioned capitation taxes or direct taxation, and to have violated the rights of all citizens and residents of the Plaintiff States and of the United States, including NFIB members and small business owners and the Individual Plaintiffs, to be free from unconstitutional taxation;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, including their agencies, officials, and employees; the citizens and residents of the Plaintiff States; NFIB members and small business owners; and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT FOUR

COERCION AND COMMANDEERING AS TO MEDICAID

(Const. art. I & amends. IX, X)

83. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

84. Plaintiff States cannot afford the unfunded costs of participating under the Act, but effectively have no choice other than to participate.

85. The Act exceeds Congress's powers under Article I of the Constitution, and cannot be upheld under the Commerce Clause, Const. art. I, §8; the Taxing and Spending Clause, *id.*; or any other provision of the Constitution.

86. By using Medicaid to reach universal healthcare coverage goals and forcing fundamental changes in the nature and scope of the Medicaid program upon the Plaintiff States, by denying Plaintiff States any choice with respect to new Medicaid requirements and denying them flexibility to limit the fiscal impact of those changes, by effectively co-opting Plaintiff States' control over their budgetary processes and legislative agendas through compelling them to assume costs they cannot

afford, by forcing Plaintiff States to become responsible for providing healthcare services for all Medicaid enrollees, by requiring Plaintiff States to carry out insurance mandates and establish intrastate insurance programs and regulations for federal purposes, by interfering in the Plaintiff States' relationships with their employees with respect to healthcare coverage, by commandeering the Plaintiff States and their employees as agents of the federal government's regulatory scheme at the States' own cost, and by interfering in the Plaintiff States' sovereignty, the Act violates Article IV, section 4 of the Constitution, depriving Plaintiff States of their sovereignty and their right to a republican form of government; violates the Ninth and Tenth Amendments; and violates the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress' powers under Article I of the Constitution and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

COUNT FIVE

COERCION AND COMMANDEERING AS TO HEALTHCARE INSURANCE

(Const. art. I & amends. IX, X)

87. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

88. By requiring the Plaintiff States to carry out insurance mandates and establish intrastate insurance programs for federal purposes under threat of removing or significantly curtailing their long-held regulatory authority as to intrastate insurance, and by commandeering the Plaintiff States and their employees as agents of the federal government's regulatory scheme at the States' own cost, the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress' powers under Article I of the Constitution and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

COUNT SIX

INTERFERENCE WITH THE STATES' SOVEREIGNTY AS EMPLOYERS AND PERFORMANCE OF GOVERNMENTAL FUNCTIONS

(Const. art. I & amends. IX, X)

89. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

90. By imposing new employer healthcare insurance mandates on the Plaintiff States, by requiring that they automatically enroll and continue enrollment of employees in healthcare plans, by subjecting States to penalties and taxes depending upon plan attributes and individual employee coverage decisions, and by burdening the States' ability to procure goods and services and to carry out governmental functions, the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

Case No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL MCCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; KATHLEEN SEBELIUS, IN HER OFFICIAL CAPACITY AS THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF THE TREASURY; TIMOTHY F. GEITHNER, IN HIS OFFICIAL CAPACITY AS THE SECRETARY OF THE UNITED STATES DEPARTMENT OF THE TREASURY; UNITED STATES DEPARTMENT OF LABOR; AND HILDA L. SOLIS, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR, DEFENDANTS

Filed: Nov. 4, 2010

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Pursuant to Rule 56, Federal Rules of Civil Procedure, Plaintiffs hereby move for summary judgment in their favor on Counts One and Four of the Amended Complaint. As shown in their Memorandum in Support, and as supported by their Statement of Material Facts and Appendix of Exhibits, no genuine issue of material fact exists in this action, and Plaintiffs are entitled to judgment in their favor as a matter of law.

The provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("HCERA"), ("ACA") that impose the Individual Mandate on Americans, requiring that they obtain qualifying healthcare insurance coverage, are unconstitutional and cannot be severed from the balance of the ACA. In addition, the provisions of the ACA that alter the nature of the Medicaid program and the States' burdens and costs for that program are unconstitutional and cannot be severed from the balance of the ACA.

For these reasons, the ACA should be declared unconstitutional and Defendants should be enjoined from enforcing the ACA, as requested in the Amended Complaint.

Respectfully submitted,

BILL MCCOLLUM
ATTORNEY GENERAL OF FLORIDA

/s/ BLAINE H. WINSHIP
BLAINE H. WINSHIP (Fla. Bar No. 0356913)
Special Counsel
Joseph W. Jacquot (Fla. Bar No. 189715)
Deputy Attorney General

Scott D. Makar (Fla. Bar No. 709697)
Solicitor General
Louis F. Hubener (Fla. Bar No. 0140084)
Timothy D. Osterhaus (Fla. Bar No. 0133728)
Deputy Solicitors General
Office of the Attorney General of Florida
The Capitol, Suite PL-01
Tallahassee, Florida 32399-1050
Telephone: (850) 414-3300
Facsimile: (850) 488-4872
Email: blaine.winship@ myfloridalegal.com
Attorneys for Plaintiff States

David B. Rivkin (D.C. Bar No. 394446)
Lee A. Casey (D.C. Bar No. 447443)
Baker & Hostetler LLP
1050 Connecticut Avenue, N.W., Ste. 1100
Washington, DC 20036
Telephone: (202) 861-1731
Facsimile: (202) 861-1783
Attorneys for Plaintiff States, National Federation of Independent Business, Mary Brown, and Kaj Ahlburg

Katherine J. Spohn
Special Counsel to the Attorney General
Office of the Attorney General of Nebraska
2115 State Capitol Building
Lincoln, Nebraska 68508
Telephone: (402) 471-2834
Facsimile: (402) 471-1929
Email: katie.spohn@nebraska.gov

Attorneys for Plaintiff the State of Nebraska

Karen R. Harned
Executive Director
National Federation of
Independent Business
Small Business Legal
Center
1201 F. Street, N.W.,

Suite 200
Washington, DC 20004
Telephone: (202) 314-2061
Facsimile: (202) 554-5572
Of counsel for Plaintiff NationalFederation of Independent Business

Bill Cobb
Deputy Attorney General
for Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548, Capitol
Station

Austin, Texas 78711-2548
Telephone: (512) 475-0131
Facsimile: (512) 936-0545
Email: bill.cobb@oag.
state.tx.us
Attorneys for Plaintiff the State of Texas

CERTIFICATE OF SERVICE

I hereby certify that, on this 4th day of November, 2010, a copy of the foregoing Plaintiff's Motion for Summary Judgment was served on counsel of record for all Defendants through the Court's Notice of Electronic Filing system.

/s/ BLAINE H. WINSHIP
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney General
of Florida

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
PENSACOLA DIVISION

Case No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL MCCOLLUM, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS

Filed: Nov. 4, 2010

DEFENDANT'S MOTION FOR SUMMARY JUDGEMENT

Defendants, by undersigned counsel, hereby move the Court, pursuant to Federal Rule of Civil Procedure 56, for summary judgment on Claims One and Four of the Amended Complaint. The grounds for this motion are set forth in the accompanying memorandum of law.

Dated: Nov. 4, 2010 Respectfully submitted,

TONY WEST
Assistant Attorney General

IAN HEATH GERSHENGORN
Deputy Assistant Attorney
General

THOMAS F. KIRWIN
United States Attorney

SHEILA LIEBER
Deputy Director

/s/ ERIC BECKENHAUER
BRIAN KENNEDY,
D.C. Bar No. 228726
Senior Trial Counsel
ERIC B. BECKENHAUER,
Cal. Bar No. 237526
Trial Attorney
U.S. Department of Justice
Civil Division, Federal Programs
Branch
20 Massachusetts Ave. NW
Washington, DC 20530
Telephone: (202) 514-3338
Facsimile: (202) 616-8470
E-mail:
eric.beckenhauer@usdoj.gov

Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on November 4, 2010, the foregoing document was filed with the Clerk of Court via the CM/ECF system, causing it to be served on Plaintiffs' counsel of record.

/s/ ERIC B. BECKENHAUER
ERIC B. BECKENHAUER

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH
BILL MCCOLLUM, ATTORNEY GENERAL OF THE
STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES, ET AL., DEFENDANTS

DECLARATION OF PLAINTIFF MARY BROWN IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, Mary Brown. under the provisions of 28 U.S.C. § 1746, hereby declare as follows:

1. I am 55 years old, a citizen of the United States, and a citizen and resident of the State of Florida. I am personally familiar with the facts contained herein, and I am competent to testify thereto.

2. I am a member of the National Federation of Independent Business ("NFIB") in good standing.

3. I am the Co-Owner, Secretary, and Treasurer of Brown & Dockery, Inc., an automobile repair facility located at 2707 E. 15th St., Panama City, Florida 32405. My business has two employees apart from myself.

4. I am married and have no children under the age of 26.

5. I do not have health insurance and have not had health insurance for the past four years. I devote my financial resources to maintaining my business and paying my employees.

6. I regularly use my personal funds to meet my business expenses. I have recently held off cashing my paycheck on occasion to meet my business expenses.

7. I do not qualify for Medicare or Medicaid and I do not receive health or medical benefits from either program. I do not expect to qualify for Medicare in or before 2014, or for Medicaid under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).

8. I am subject to the ACA's individual insurance mandate. I object to being forced to obtain and maintain qualifying health insurance coverage for myself and my dependents, or to pay a penalty for failing to have such insurance, and to the ACA's unconstitutional overreaching and its encroachment on the States' sovereignty. I do not believe that the cost of health insurance coverage is a wise or acceptable use of my financial resources.

9. Both my business and myself will be harmed if I must purchase health care insurance coverage, which I neither want nor need, to comply with the ACA, or pay the prescribed penalties for non-compliance. This is because, in either case, I will be forced to divert financial resources from my own priorities, and particularly from supporting and running my business as I consider to be best and most advantageous. I believe that the added costs of ACA compliant insurance will threaten my ability to maintain my own, independent business.

10. To comply with the individual mandate, I would be forced to reorder my personal and business affairs. Well in advance of 2014, I must now investigate whether and how to both obtain and maintain the required insurance and at the same time to support my business and to make it grow.

11. I must also now investigate the impact that complying with the individual insurance mandate will have on my priorities and especially whether, in light of the costs of complying with the individual mandate, my independent business can continue to be a viable going concern, or whether to comply I would have to layoff my employees, close my business, and seek employment that provides qualifying health insurance as a benefit.

12. In order to comply with the ACA's individual insurance mandate, I believe that I would have to plan and take appropriate action before 2014 if I am to avoid being penalized for not complying when this requirement becomes effective.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 20 day of Oct., 2010 at 11:15 AM

/s/ MARY BROWN
MARY BROWN

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL MCCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS

DECLARATION OF PLAINTIFF KAJ AHLBURG IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, Kaj Ahlburg, under the provisions of 28 U.S.C. § 1746, hereby declare as follows:

1. I am 51 years old, a citizen of the United States, and a citizen and resident of the State of Washington. I am personally familiar with the facts contained herein, and I am competent to testify thereto.

2. I am retired, holding no present employment.

3. I am married and have two children under the age of 26.

4. I do not have health insurance and have not had health insurance for the past six years. I have no intention or desire to purchase health insurance in the future, as I am now and reasonably expect to remain financially

capable of fully paying for my and my family's healthcare services out of my own resources as needed.

5. I do not qualify for Medicare or Medicaid and I do not receive health or medical benefits from either program. I do not expect to qualify for Medicare in or before 2014, or for Medicaid under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).

6. I am subject to the ACA's individual insurance mandate. I object to being forced to obtain and maintain qualifying health care insurance for myself and my dependents, or to pay a penalty for failing to have such insurance, and to the ACA's unconstitutional overreaching and its encroachment on the States' sovereignty.

7. I do not believe that the cost of health insurance in general, or in particular the cost of coverage that is compliant with the ACA, represents a sensible or acceptable use of my financial resources.

8. I will be harmed if I am required to obtain and maintain such insurance, which I neither need nor want, or to pay the prescribed penalties for non-compliance. This is because, in either case, I will be forced to divert funds from other priorities which I know to be more important for myself and my family.

9. To comply with the individual insurance mandate, and well in advance of 2014, I must now investigate whether and how to rearrange my personal financial affairs so as to ensure the availability of sufficient funds to pay the premiums associated with ACA compliant insurance coverage, and to establish what impact meeting this requirement will have on my priorities for my-

self and my family, particularly how these priorities would have to change as a result.

10. In order to comply with the individual mandate I believe I would have to plan and take appropriate action before 2014 so as to meet its requirements if I am to avoid being penalized for not complying when this requirement becomes effective.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 1st day of Nov., 2010 at Port Angeles, Washington.

/s/ KAJ AHLBURG
KAJ AHLBURG

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL McCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS

DECLARATION OF PLAINTIFF DONALD A. DANNER IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, Donald A. Danner, under the provisions of 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18. I am personally familiar with the facts contained in this declaration, and I am competent to testify thereto.

2. I am the President and Chief Executive Officer of the National Federation of Independent Business ("NFIB"). In this capacity, I am intimately familiar with the structure, operations and finances of NFIB and have personal knowledge of the injuries done to NFIB and many of its members as a result of the passage and enactment of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No.111-148, 124 Stat. 119 (2010).

3. NFIB, a California nonprofit mutual benefit corporation, is the nation's leading association of small businesses and has a presence in all 50 States and the District of Columbia. The NFIB Small Business Legal Center is a nonprofit, public interest law firm established to provide legal resources and be the voice for small businesses in the nation's courts through representation on issues of public interest affecting small businesses.

4. NFIB's mission is to promote and protect the rights of its members to own, operate, and earn success in their businesses, in accordance with lawfully-imposed government requirements. In accordance with NFIB's articles of incorporation, a public document with which I am personally familiar, its corporate purpose is, among other things, "[t]o promote the economic, financial and political welfare of its members," "to organize the independent or small business men into an association to the end that his voice may be heard effectively in local, state, and national affairs affecting small business," and "[t]o foster the promotion and advancement of civic, commercial, industrial and political welfare of its members in their respective communities."

5. NFIB's membership includes nearly 40,000 sole proprietors. Many of these individuals operate their businesses themselves or are otherwise personally involved in the day-to-day management of their enterprise.

6. NFIB's service to its members includes providing information regarding legal and regulatory issues faced by small businesses, as well as information and advice regarding compliance with federal and state reg-

ulatory requirements, including individuals who own and operate their own business.

7. Healthcare-related issues have been among NFIB's highest public policy priorities in the past twenty years. NFIB's Research Foundation has conducted at least five polls and surveys specifically to determine the burden to its small business members of offering health care benefits to employees. These polls and surveys have resulted in five publications: (1) "NFIB Small Business Poll: Health Insurance" (2003); (2) "Price Sensitivity in Health Care: Implications for Health Care Policy" (2005); (3) "A Study of Administrative Costs Accruing to Association Health Plans" (2005); (4) "NFIB Small Business Poll: Health Insurance, Purchasing" (2007); and (5) "Health Insurance Reform in an Experimental Market" (2009).

8. In addition, NFIB members guide the organization's public policy positions through periodic "Member Ballots." In this way NFIB advances the consensus of its members as a whole rather than the more narrow interests of any particular trade group.

9. Since March of 1985, NFIB has asked its members a ballot question on either healthcare or health insurance at least 63 times. Of those questions, eleven dealt with employer-mandated healthcare and on five occasions members were asked whether Congress should establish a mandatory national health insurance program or whether individuals should be required to obtain health insurance coverage for themselves. On all but one occasion (1993), NFIB members overwhelmingly rejected adoption of an individual health insurance mandate.

10. NFIB also regularly produces a "Problems and Priorities" report identifying the issues of greatest concern to its membership. This publication is based on the responses of a large sample of NFIB's small business owner membership to a questionnaire. The questionnaire presents 75 potential business problems, including those related to public policy. Respondents are asked to rate the severity of each potential problem on a scale of 1 to 7, with answers ranging from "Critical Problem" to 'Not a Problem."

11. Since 1986, the cost of health insurance has been the top priority of NFIB's small business members. NFIB sole proprietor members also rate the cost of health insurance as their top concern.

12. As demonstrated by the declarations of NFIB members submitted in this case, many NFIB members are suffering actual and immediate injuries because of the ACA's mandate that individuals obtain and maintain a statutorily established minimum level of health insurance coverage for themselves and their families. These uninsured small business owners are and will continue to be subject to the ACA's individual insurance mandate and object to being forced to obtain healthcare insurance coverage for themselves and their dependents or pay a penalty. For individuals and small business owners who do not have insurance, and especially sole proprietors, the costs of obtaining qualifying coverage will mean that they have fewer financial resources available to operate and grow their businesses. These members will be forced to divert resources from their business endeavors, or otherwise reorder their economic circumstances and priorities, to obtain the required coverage, regardless of their own conclusions regarding whether

or not having such coverage for themselves and their dependents is a worthwhile cost of doing business. In some cases, the costs associated with obtaining and maintaining ACA qualifying health insurance will threaten members' ability to maintain their own, independent small businesses as viable, going concerns.

13. In addition, the passage and enactment of the ACA has resulted in significant new costs for NFIB. Since passage, NFIB has been required to expend substantial additional resources to advise its membership on ACA-related compliance issues.

14. To this end, NFIB paid staff has to date collectively spent approximately 2,430 hours helping NFIB members understand and comply with the ACA. This is an unprecedented amount of time and resources for NFIB to spend on one issue.

15. This new cost represents 2% of NFIB's total state and federal policy budget and constitutes a significant burden on NFIB.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 2nd day of Nov., 2010 at Washington, D.C.

/s/ DONALD A. DANNER
DONALD A. DANNER

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL MCCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS

DECLARATION OF PLAINTIFF DANA GRIMES IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, Dana Grimes, under the provisions of 28 U.S.C. § 1746, hereby declare as follows:

1. I am 48 years old, a citizen of the United States, and a citizen and resident of the State of New York. I am personally familiar with the facts contained in this declaration and I am competent to testify thereto.

2. I am a member of the National Federation of Independent Business ("NFIB") in good standing.

3. I am the sole proprietor of Premier Renovations, located at 65 County Route 52, Greenwich, NY 12834. My business provides building and home contracting services and has no employees.

4. I am divorced and have two children under the age of 26. My children live out-of-state with my ex-wife.

5. I have used my personal funds to meet my business expenses when necessary and I invest a substantial amount of my income back into my business.

6. I do not have health insurance. Until recently, I had health insurance provided through the U.S. Chamber of Commerce, but I chose to terminate my coverage because I believed it was too expensive. I am in excellent health and my medical expenses are roughly $100 per year, but my previous insurance cost me $6000 per year. I last visited the doctor after injuring myself at work with a chainsaw, and I fully paid my own medical expenses out-of-pocket.

7. I do not qualify for Medicare or Medicaid and I do not receive health or medical benefits from either program. I do not expect to qualify for Medicare in or before 2014, or for Medicaid under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).

8. I will be subject to the ACA's individual insurance mandate. I object to the ACA's unconstitutional overreaching and to being forced to obtain and maintain qualifying health care insurance for myself and my dependents, or to pay a penalty for failing to have such insurance. I do not wish to have such insurance and I do not believe that the costs associated with health insurance are a wise or acceptable use of my financial resources.

9. Both my business and myself will be harmed if I must purchase health care insurance coverage, which I neither want nor need, to comply with the ACA, or pay

the prescribed penalties for non-compliance. This is because, in either case, I will be forced to divert financial resources away from my own priorities, and particularly from supporting and running my business as I consider to be best and most advantageous. I believe that the added costs of ACA compliant insurance will make it difficult, if not impossible, for me to remain in business.

10. To comply with the individual mandate, I would be forced to reorder my personal and business affairs. Well in advance of 2014, I must now investigate whether and how to both obtain and maintain the required insurance and at the same time to support my business and make it grow.

11. In particular, I must investigate what impact the costs of compliance with the individual insurance mandate will have on my priorities, and especially whether, in light of those costs, my independent business can continue to be a viable going concern, or whether to comply I would have to close my business and seek employment that provides qualifying health insurance coverage as a benefit.

12. In order to comply with the ACA's individual insurance mandate, I believe that I would also have to plan and take appropriate action before 2014 if I am to avoid being penalized for not complying when this requirement becomes effective.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 21st day of Nov., 2010 at 3:30 p.m.

/s/ DANA GRIMES
DANA GRIMES

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL
MCCOLLUM, ATTORNEY GENERAL OF THE
STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES, ET AL., DEFENDANTS

DECLARATION OF PLAINTIFF DAVID KLEMENCIC IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, David Klemencic, under the provisions of 28 U.S.C. § 1746, hereby declare as follows:

1. I am 50 years old, a citizen of the United States, and a citizen and resident of the State of West Virginia. I am personally familiar with the facts contained in this declaration, and I am competent to testify thereto.

2. I am a member of the National Federation of Independent Business ("NFIB") in good standing.

3. I am the sole proprietor of Ellenboro Floors, located at 108 W. Washington Street, Ellenboro, West Virginia 26346. My business sells flooring. I have no employees.

4. I am married and have no children under the age of 26.

5. My business and personal funds are not kept separate, and I use my personal funds to pay my business expenses when necessary.

6. I do not have health insurance. My wife has insurance through her employer, Tim Horton's Restaurant, but I am not covered under it. I last had health insurance over 12 years ago. I have looked into purchasing health insurance within the past year but have determined that it is too expensive.

7. I do not qualify for Medicare or Medicaid and I do not receive health or medical benefits from either program. I do not expect to qualify for Medicare in or before 2014, or for Medicaid under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010).

8. I am subject to the ACA's individual insurance mandate. I object to the ACA's unconstitutional overreaching and to being forced to obtain and maintain qualifying health care insurance for myself and my dependents, or to pay a penalty for failing to have such insurance. I do not wish to have such insurance and do not believe that the cost of health insurance is a wise or acceptable use of my financial resources.

9. Both my business and myself will be harmed if I must purchase health care insurance coverage, which I neither want nor need, to comply with the ACA, or pay the prescribed penalties for non-compliance. This is because, in either case, I will be forced to divert financial resources from my own priorities, and particularly from supporting and running my business as I consider

to be best and most advantageous. I believe that the added costs of ACA compliant insurance will threaten my ability to maintain my own, independent business.

10. To comply with the individual mandate, I would be forced to reorder my personal and business affairs. Well in advance of 2014, I must now investigate whether and how to both obtain and maintain the required insurance and at the same time to support my business and to make it grow.

11. In particular, I must investigate what impact the costs of compliance with the individual insurance mandate will have on my priorities, and especially whether, in light of those costs, my independent business can continue to be a viable going concern, or whether to comply I must close my business and seek employment that provides qualifying health insurance as a benefit.

12. In order to comply with the ACA's individual insurance mandate, I believe that I would also have to plan and take appropriate action before 2014 if I am to avoid being penalized for not complying when this requirement becomes effective.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 22nd day of Nov., 2010 at 8:00 AM

/s/ DAVID KLEMENCIC
DAVID KLEMENCIC

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL MCCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS

DECLARATION OF PLAINTIFF PAUL MCCLAIN IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

I, Paul McClain, under the provisions of 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18, a citizen of the United States, and a citizen and resident of the State of Indiana. I am personally familiar with the facts contained herein, and I am competent to testify thereto.

2. I am a member of the National Federation of Independent Business ("NFIB") in good standing.

3. I am the sole proprietor of AJ Towing & Recovery, located at 1415 Lafayette St., Fort Wayne, Indiana 46802. My business provides automotive towing and recovery services and has two employees.

4. I sometimes use my personal funds to meet my business expenses.

5. I do not have health insurance, nor have I had health insurance as an adult in the past. I do not offer health insurance to my employees.

6. I do not qualify for Medicare or Medicaid and I do not receive health or medical benefits from either program. I do not expect to qualify for Medicare in or before 2014, or for Medicaid under the Patient Protection and Affordable Care Act ("ACA"). Pub. L. No. 111-148. 124 Stat. 119 (20 10).

7. I am subject to the ACA's individual insurance mandate. I object to the ACA's unconstitutional overreaching, and to being forced to obtain and maintain qualifying health care insurance for myself and my dependents, or to pay a penalty for failing to have such insurance. I do not believe that the cost of health insurance is a wise or acceptable use of my financial resources.

8. Both my business and myself will be harmed if I must purchase health care insurance coverage, which I neither want nor need, to comply with the ACA, or pay the prescribed penalties for non-compliance. This is because, in either case, I will be forced to divert financial resources away from my own priorities, and particularly from supporting and running my business as I consider to be best and most advantageous. I believe that the added costs of ACA compliant insurance will make it difficult if not impossible, for me to remain in business.

9. To comply with the individual mandate. I would be forced to reorder my personal and business affairs.

Well in advance of 2014, I must now investigate whether and how to both obtain and maintain the required insurance and at the same time to support my business and to make it grow.

10. In particular, I must investigate what impact the costs of compliance with the individual insurance mandate will have on my priorities, and especially whether, in light of those costs, my independent business can continue to be a viable going concern, or whether to comply I must close my business and seek employment that provides qualifying health insurance as a benefit.

11. In order to comply with the ACA's individual insurance mandate, I believe that I would also have to plan and take appropriate action before 2014 if I am to avoid being penalized for not complying when this requirement becomes effective.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 21 day of Oct., 2010 at 3:00 1415 Lafayette St. Fort Wayne, IN.

/s/ PAUL MCCLAIN
PAUL MCCLAIN

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL MCCOLLUM, ATTORNEY GENERAL OF THE STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS

DECLARATION OF PLAINTIFF TIMOTHY THOMPSON IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I, Timothy Thompson, under the provisions of 28 U.S.C. § 1746, hereby declare as follows:

1. I am 46 years old, a citizen of the United States, and a citizen and resident of the State of Ohio. I am personally familiar with the facts contained herein, and I am competent to testify thereto.

2. I am a member of the Nationa Federation of Independent Business ("NFIB") in good standing.

3. I am the sole proprietor of Thompson's Automotive, located at 893 1/2 U.S. Highway 250, North Ashland, Ohio 44805. My business provides automotive repair services and has no employees.

4. I am single and have two children under the age of 26.

5. I regularly use my personal funds to meet my business expenses.

6. I do not have health insurance. I last had health insurance many years ago when I worked at a factory.

7. I do not qualify for Medicare or Medicaid and I do not receive health or medical benefits from either program. I do not expect to qualify for Medicare in or before 2014, or for Medicaid under the Patient Protection and Affordable Care Act ("HACA"), Pub, L. No, 111-148, 124 Stat. 119 (2010).

8. I am subject to the ACA's individual insurance mandate. I object to the ACA's unconstitutional overreaching, and to being forced to obtain and maintain qualifying health care insurance for myself and my dependents, or to pay a penalty for failing to have such insurance. I do not wish to have health insurance, and I do not believe that the costs associated with that coverage are a wise or acceptable use of my financial resources.

9. Both my business and myself will be harmed if I must purchase health care insurance coverage, which I neither want nor need, to comply with the ACA, or pay the prescribed penalties for non-compliance. This is because, in either case, I will be forced to divert financial resources away from my own priorities, and particularly from supporting and running my business as I consider to be best and most advantageous. I believe that the added costs of ACA compliant health insurance will threaten my ability to maintain my own, independent business.

10. To comply with the individual mandate I would be forced to reorder my personal and business affairs. Well in advance of 2014, I must now investigate whether and how to both obtain and maintain the required insurance and at the same time to support my business and to make it grow.

11. In particular, I must investigate what impact the costs of compliance with the individual insurance mandate will have on my priorities, and especially whether, in light of those costs, my independent business can continue to be a viable going concern, or whether to comply I must close my business and seek employment that provides qualifying health insurance as a benefit.

12. In order to comply with the ACA's individual insurance mandate, I believe that I would also have to plan and take appropriate action before 2014 if I am to avoid being penalized for not complying when this requirement becomes effective.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 21 day of Oct., 2010 at 8:00 AM Ashland, OH.

/s/ TIMOTHY THOMPSON
TIMOTHY THOMPSON

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:01-cv-91-RV/EMT

STATE OF FLORIDA, BY AND THROUGH BILL
MCCOLLUM, ATTORNEY GENERAL OF THE
STATE OF FLORIDA, ET AL., PLAINTIFFS

v.

UNITED STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES, ET AL., DEFENDANTS

DECLARATION OF ELIZABETH DUDEK

Pursuant to 28 U.S.C. § 1746, I, Elizabeth Dudek, declare the following:

1. My name is Elizabeth Dudek. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida Agency for Health Care Administration (AHCA) as the Interim Secretary.
2. I have served as Interim Secretary since September 2010.
3. As the Interim Secretary, I am the highest ranking official in AHCA and am responsible for all activities of the Agency including the operation of the Medicaid program.

4. Providing this declaration is within the scope of my authority and the facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration. The facts and projections contained in this declaration regarding the impact of PPACA, however, were not originally prepared in anticipation of this or any other litigation. AHCA originally compiled the facts and projections contained herein as part of its responsibility to report to Florida's elected officials on developments that will impact the Medicaid program. AHCA has prepared and maintained those projections in the regular course of its state business.

A. Florida's Medicaid Program

5. Florida participates in the Medicaid program, and has participated continuously in the program for more than 40 years. The Federal Medicaid law requires states to designate a "single state agency" responsible for the implementation of the state's Medicaid program. 42 U.S.C. § 1396a(a)(5). [The federal law does, however, allow states under certain circumstances to bifurcate their Medicaid programs so that one agency makes eligibility determinations, while another agency serves as the "single state agency" for those found eligible. *Id.* Florida has done just that, with the Florida Department of Children and Families (DCF) conducting eligibility determinations and AHCA administering the program for those found eligi-

ble. As Florida's eligibility agency, DCF may also be impacted by PPACA.]

6. As Florida's single state agency, AHCA cannot and does not delegate, to anyone other than its own officials, the authority to issue policies, rules, and regulations on Medicaid program matters. 42 C.F.R. § 431.10(e)(1)(ii). No other state agency or entity has the authority to change or disapprove of any of AHCA's administrative decisions, and no other state agency or entity can substitute its judgment for AHCA's with respect to the application of policies, rules, and regulations that AHCA has issued. 42 C.F.R. § 431.10(e)(3). *Id.*

7. As of fiscal year 2008-09, Florida's total Medicaid program budget (including federal and state dollars) consumed 24.16% percent of the State's total annual budget. This percentage has steadily increased over the years. In fiscal year 1991-1992, for example, the total Medicaid program budget consumed 13.10% of the total state budget.

8. For the current fiscal year, AHCA estimates that it will spend $20.2 billion dollars on the Medicaid program, which will exceed 28% of the state's total budget. AHCA anticipates that the program will serve over 2.9 million eligible recipients per month during this fiscal year.

B. Impact of PPACA

Medicaid Eligibility Expansion and Increased Rates for Primary Care Practitioners

9. PPACA requires states to cover eligibility groups not previously covered.

10. Currently, Florida Medicaid has a variety of eligibility thresholds that depend on the age and condition of the recipient. Children from birth to 1, for example, are eligible if their family income does not exceed 185% of federal poverty level. Children from 1 through 5 are eligible if their family income does not exceed 133% of federal poverty level. Children 6 through 18 are eligible if their family income does not exceed 100% of federal poverty level. Children 19 and 20, as well as adults with children who are Medicaid-eligible, are eligible if their income does not exceed 22% of federal poverty level. Aged, blind, and disabled adults are eligible if their income does not exceed 74% of federal poverty level. Aged and disabled adults who need long term care (e.g. a nursing home) are eligible if their income does not exceed 222% of federal poverty level. Pregnant women are eligible if their income does not exceed 185% of federal poverty level. Women with breast and/or cervical cancer are eligible in their income does not exceed 200% of federal poverty level. Women who have lost Medicaid coverage for any reason are provided limited family planning services for up to 24 months through the Family Planning Waiver. The program does not currently serve

able-bodied, childless adults not otherwise covered in a current categorical coverage group.

11. Starting in 2014, PPACA requires that state Medicaid programs serve all individuals under 65 with incomes of up to 133% of the federal poverty level.[1] PPACA also requires a 5% income disregard for all populations (effectively raising the eligibility threshold to 138% of the federal poverty level). These newly-mandated populations ("newly eligibles") include childless adults whom the Florida Medicaid program has not previously served. It also expands eligibility in Florida for children ages 6-20 and for parents, the aged, the blind, and the disabled who do not need long term care.

12. PPACA provides for enhanced federal financial participation for the newly eligible populations. The Federal government uses the Federal Medical Assistance Percentage (or FMAP) to determine the amount of Federal matching funds for state's expenditures for assistance payments for certain social services, including Medicaid. Through the FMAP, the federal government has traditionally funded about 55% of the Florida Medicaid program, with Florida generally funding the other 45%. With respect to the newly eligible populations, the federal government will fund 100% of the cost of serving the newly eligible population from 2014 through calendar year 2016. Thereafter, states are required to start contributing to the cost of serving the expansion

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[1] PPACA, § 2001(a).

population, with the federal government's share dropping to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond.

13. Currently, Florida has broad discretion to set reimbursement rates for health care providers who participate in the Medicaid program. Starting in state fiscal year 2012-13 (January 1, 2013), PPACA will require Florida to reimburse for certain primary care procedure codes used in the Medicaid program at a federally-mandated rate (in essence, they must be reimbursed at the same rate as in the federal Medi*care* program). This requirement will continue through December 31, 2014. During this period the state will received 100% federal funding for the cost of the increased reimbursements. For estimation purposes, AHCA assumes that the federally-required rate increase would continue beyond the two-year period delineated in the law and these costs would then be partially funded with state funds.

14. AHCA has made projections regarding the fiscal and enrollment impact of PPACA, and presented its projections to the Florida legislature. The power point presentation created for this purpose is attached as Attachment 1 *(AHCA Overview of Federal Affordable Care Act, August 18, 2010)*. The power point presentation describes the various assumptions that went into AHCA's projections, and these assumptions can be found at pages 4 through 10 of the presentation. See Attachment 1. This power point presentation was not prepared in anticipation of litigation.

AHCA officials prepared it and have maintained it in the regular course of their public business.

15. The AHCA presentation projects the estimated cost to Florida of $142,460,765.00 in state general revenue in Florida's 2013-2014 fiscal year. This amount increases going forward, and by 2018-19 the projected costs to Florida are estimated to be just over a billion dollars per year, or $1,012,206,268.00, in state general revenue.

16. When fully implemented, AHCA projects that PPACA will add an additional 1.8 million people to Florida's Medicaid annual rolls, meaning that the program will, by as early as 2015, serve more than 4.5 million people annually.

17. AHCA developed projections regarding the growth in costs and enrollment as a result of PPACA which project that PPACA will result in the expansion of the Florida Medicaid caseload in four ways. First, it will extend Medicaid to persons previously ineligible (the "newly eligible"). By SFY 2018- 2019, AHCA projects that this population will cost Florida roughly $351 million per year in state revenue.

18. Second, AHCA projects that PPACA will increase program enrollment of uninsured persons who are currently eligible for Medicaid but who, for whatever reason, are not currently enrolled. By SFY 2018- 2019, AHCA projects that this population will cost Florida about $574 million per year in state revenue. The estimates developed reflect a higher commitment of state general revenue as the state will continue to receive the regular FMAP rate for this population.

19. Third, AHCA projects that PPACA will prompt some low-income individuals, who will be newly eligible for the Medicaid program under PPACA, to drop their private insurance coverage and enroll in Medicaid. By SFY 2018- 2019, AHCA projects that this population will cost Florida almost $47 million per year in state revenue.

20. Fourth, AHCA's projects reflect the transition of coverage of some CHIP enrollees to coverage under the Medicaid program. AHCA projects that children between the ages of 6-18 in families with incomes between 100-133% of FPL and currently covered by CHIP will be enrolled in Medicaid. AHCA projects that, by SFY 2018-2019, this change will cost Florida about $78 million in state revenue a year, while saving the state CHIP program about $62 million per year, for a net cost of roughly $16 million per year in state revenue.

21. Also, AHCA's projections assume that the changes PPACA makes to physician reimbursement rates will cost Florida an additional $391 million per year in state revenue by SFY 2018-2019.

22. In sum, AHCA projects that the expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Florida's costs, less so in the early years but more so after 2016.

Restrictions on State Ability to Change Eligibility and Tailor Medicaid Programs

23. Traditionally, Medicaid programs have had some authority to develop eligibility standards, including reducing eligibility for groups above mandatory coverage levels. Starting on the date of its signing (March 23, 2010), PPACA takes this type of policy-making authority away. PPACA requires all states to maintain their current eligibility standards for adults through 2014, and for children through 2019. This is known as the "maintenance of effort" requirement.

24. The maintenance of effort requirement means that Florida cannot make any change to eligibility that would render a person ineligible for Medicaid or CHIP benefits when that same person would have been eligible for benefits on March 23, 2010. If Florida fails to comply with the maintenance of effort requirement, it risks losing federal matching funds for all Medicaid programs, including funds that support services to pregnant women, children, and the aged and disabled populations.

25. PPACA establishes separate maintenance of effort requirements for the adult and children's Medicaid populations and, as a result, alters the state's expectations for coverage of optional categorically needy populations. The maintenance of effort requirement for the adult Medicaid population will remain in place until the U.S. Department of Health and Human Services (HHS) determines that an exchange established by the state under PPACA section 1311 is fully opera-

tional.[2] The maintenance of effort requirement for CHIP and the children's Medicaid population up to age 19 will remain in effect through September 2019.[3]

26. As stated previously, consistent with federal law, Florida has opted to cover, as optional categorically needy groups: pregnant women between 150 and 185% of federal poverty level; women with breast and cervical cancer up to 200% of federal poverty level; and persons in need of long term care (e.g. nursing home services) between 74% and 222% of federal poverty level.

27. AHCA created these groups according to policy direction from state leadership. The maintenance of effort provision precludes the state from reducing or eliminating these previously optional eligibility groups as a matter of policy.

Loss of Prescription Drug Rebate Revenue

28. PPACA modifies the minimum Medicaid federal unit rebate amount for most drugs.[4] These modifications were made retroactively effective to January 1, 2010, and have the effect of reducing the supplemental rebates available to the states.

29. CMS provided initial guidance to states regarding PPACA's pharmacy rebate provisions on April 22, 2010. In this initial guidance letter, CMS indicated that it would retain the difference between the old and new rebate percent-

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[2] PPACA, § 2001(b).

[3] *Id.*

[4] PPACA, § 2501.

ages across the board for all drugs, not just for those drugs for which there is an actual increase in the federal rebate amount due to the Act. Final guidance was distributed to State Medicaid Programs on September 28, 2010. In this letter, CMS revised the previous instructions concerning the Federal offset of Medicaid prescription drug rebates. At this time, the Agency is still waiting for additional information from CMS so that the Agency can invoice for federal 2010 rebates for the Fee-For-Service program as well as begin invoicing for federal rebates based on utilization from the Medicaid Managed Care Plans.

30. AHCA currently estimates that Florida will lose approximately $40 million in rebate revenue from SFY 2010-2011 for those drugs for which we are receiving rebates in excess of the current minimums.[5] During that same time frame, the state will receive approximately $551 million in rebate revenue.[6]

The PPACA Depends Upon State Participation in Medicaid to Achieve Its Coverage Goals

31. The PPACA provides subsidies and credits for individuals between 133% and 400% of the federal poverty level who obtain qualified coverage through a health insurance exchange, but relies solely upon state participation in Medicaid to

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[5] These projections were developed by AHCA based on __ SFY 2010-2011 ___.

[6] *Id.*

cover individuals up to 133% of the federal poverty level.

32. In Florida, Medicaid covers and pays for health care services for almost 3 million persons, including 27% of Florida's children; pays for over 50% of Florida childbirths; pays for 63% of nursing home days; delivers services through more than 80,000 individual providers and 23 managed care plans.

33. If Florida's Medicaid and CHIP programs were ended, no current program exists that would cover the healthcare costs of individuals at 133% of the poverty level and, absent planning and implementation of some programmatic substitute, Florida would face a health care emergency affecting its poorest and neediest citizens. If Florida were to cease participation abruptly without a programmatic substitute, it would likely result in severe health repercussions, including possible loss of life, among the most desperately ill and disabled within the current Medicaid population.

34. No known federal laws or regulations provide a non-abrupt process by which a state might make an orderly wind down or transition from Medicaid in a manner that would safeguard the health care of current Medicaid beneficiaries.

C. Attachments

35. I have attached the following document to this affidavit, which are true and correct copies of the original as maintained by AHCA:

#	Document Description
1	***Fla. AHCA, Overview of Federal Affordable Care Act, August 18, 2010***

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on Nov. 3, 2010, in Tallahassee, Florida.

/s/ ELIZABETH DUDEK
ELIZABETH DUDEK
Interim Secretary
Agency for Healthcare Administration

JOINT
APPENDIX

No. 11-400

In the Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTADGOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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JOINT APPENDIX ON MEDICAID

DONALD B. VERRILLI, JR. *Solicitor General* DEPARTMENT OF JUSTICE Washington, D.C. 20530 supremectbriefs@usdoj.gov (202) 514-2217	PAUL D. CLEMENT BANCROFT PLLC 1919 M Street, N.W. Suite 470 Washington, D.C. 20036 pclement@bancroftpllc.com (202) 234-0090
Counsel of Record for Respondents	*Counsel of Record for Petitioners*

January 10, 2012

Petition for Writ of Certiorari filed Sept. 28, 2011
Certiorari Granted Nov. 14, 2011

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The following opinions, decisions, judgments, and order have been omitted in printing this joint appendix because they appear in the following pages in the appendix to the Petition for Certiorari, No. 11-398:

Court of Appeals Decision
(Aug. 12, 2011) 1a

Order Granting Summary Judgment
(Jan. 3, 2011) 274a

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(Oct. 14, 2010) 394a

RELEVANT DOCKET ENTRIES

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT
Civil Docket for Case No. 11-11021

STATE OF FLORIDA, *et al.* v. U.S. DEP'T OF HEALTH & HUMAN SERVS., *et al.*

Date Filed	Document
03/09/2011	CIVIL APPEAL DOCKETED. Notice of appeal filed by Appellants Timothy F. Geithner, Kathleen Sebelius, Hilda Solis, United States Department of Health and Human Services, United States Department of Labor and United States Department of the Treasury on 03/08/2011. Appellant brief due 40 days from 03/09/2011. Fee Status: Fee Not Required.

* * *

Date Filed	Document
03/09/2011	MOTION to expedite filed by Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury. Opposition to Motion is Unknown [6257236-1]

* * *

03/10/2011 RESPONSE to Motion to expedite filed by Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021 filed by Attorney Scott Douglas Makar for Appellees State of Florida, State of Texas, State of South Carolina, State of Nebraska and State of Utah.

03/11/2011 MOTION for initial hearing en banc filed by Attorney Scott Douglas Makar for Appellees State of Florida, State of Texas, State of South Carolina, State of Nebraska and State of Utah. Opposition to Motion is Unknown [6258405-1]

* * *

03/11/2011 ORDER: Motion to expedite filed by Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury is GRANTED in part: aplt brf due 4/4, cross-aplt 5/4, cross-aple 5/18, reply brf 5/25, No ext., all brfs must be rcvd in

Clerk's office ... Aple's pet for initial hearing remains pndg ... [6257236-2] in 11-11021 JFD [11-11021, 11-11067]

* * *

03/18/2011 Response to Petition for Rehearing filed as to Attorney Samantha L. Chaifetz for Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021. [11-11021, 11-11067]

* * *

03/31/2011 ORDER: The Court having been polled at the request of several members of the Court and a majority of the Circuit Judges who are in regular service not having voted in favor of it, (Rule 35, F.R.A.P.), Appellees' Motion for Initial Hearing En Banc is DENIED [6258405-2]. Consistent with the Court's March 11, 2011, order granting in part Appellants' motion to expedite this appeal, this appeal shall also be expedited to oral argument and shall be heard at oral argument on Wednesday, June 8, 2011, at 9:30 A.M. in Atlanta, Georgia before a three judge panel randomly selected. Each side will be given one hour to present oral arguments. Further, consistent

	with Eleventh Cir. I.O.P. 7 (Identity of Panel), following Fed. R. App. 34, the identity of the panel which will hear oral argument will be disclosed no earlier than fourteen days in advance of oral argument. JFD. [11-11021, 11-11067]
	* * *
04/01/2011	E-Brief Tendered: Appellant brief for Appellant United States Department of Health and Human Services, et al. in 11-11021, Cross-Appellee United States Department of Health and Human Services, et al. in 11-11067. [11-11021, 11-11067]
04/04/2011	Appellant's brief filed by United States Department of Health and Human Services in 11-11021. Service date: 04/01/2011 [11-11021] Attorney for Appellee: Cobb - US mail; Attorney for Appellee: Katsas - US mail; Attorney for Appellant: Rivkin - US mail; Attorney for Appellee: Spohn - US mail; Attorney for Appellant: Winship - US mail; [11-11067] Attorney for Appellant: Rivkin - US mail; Attorney for Appellant: Winship - US mail; Attorney for Appellee: Katsas - US mail; Attorney for Appellee: Spohn - US mail. [11-11021, 11-11067]
04/04/2011	Expanded Record Excerpts filed by Attorney Thomas Mark Bondy for

Appellants United States Department of Labor, United States Department of Health and Human Services, Timothy F. Geithner, Hilda Solis, Kathleen Sebelius and United States Department of the Treasury in 11-11021. Service date: 04/01/2011 US mail - Attorney for Appellant(s): Rivkin, Winship; Attorney for Appellee(s): Cobb, Katsas, Spohn. [11-11021, 11-11067]

* * *

05/05/2011 E-Brief Tendered: X-Appellant brief for Appellees State of Florida, State of Nebraska, State of South Carolina, State of Texas and State of Utah in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. [11-11021, 11-11067]

* * *

05/18/2011	Appellant-Cross Appellee's Brief filed by Appellant United States Department of Health and Human Services in 11-11021. Service date: 05/17/2011 US mail - Attorney for Appellees: Clement, Katsas, Rivkin, Spohn, Winship. [11-11021, 11-11067]
05/18/2011	E-Brief Tendered: X-Appellee brief for Appellant United States Department of Health and Human Services in 11-11021. [11-11021, 11-11067]

* * *

05/24/2011	E-Brief Tendered: Reply brief of Appellants/Cross-Appellees brief for Appellants Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. [11-11021, 11-11067]--[Edited 05/25/2011 by EJ]--[Edited 05/25/2011 by EJ]

05/25/2011	Reply Brief filed by Appellants/Cross-Appellees Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah and State of Wisconsin in 11-11067. Service 05/24/2011 US mail - Attorney for Appellees: Carvin, Kaersvang, Katsas, Marshall, Mooppan. [11-11021, 11-11067]

* * *

05/31/2011	Oral argument scheduled. Argument Date: Wednesday, 06/08/2011 Argument Location: Atlanta Courtroom: Atlanta 338. [11-11021, 11-11067]
05/31/2011	ORDER: On its own motion and pursuant to Fed.R.App.P. 2, the Court hereby SUSPENDS Eleventh Circuit Rule 34-4(g) for purposes of these appeals only. Consistent with this Order, the Clerk is directed to provide CD copies of the oral argument to be held in these appeals for purchase.

	JFD [11-11021, 11-11067]
06/02/2011	ORDER: In order to remove any potential confusion about our May 31, 2011, Order, we clarify that our Order suspends only that portion of 11th Cir. Rule 34-4(g) which provides that oral argument recordings are for the exclusive use of the Court. Our May 31, 2011, Order does not suspend that portion of the Rule barring recording of oral argument proceedings by anyone other than the Court. As ordered previously, the Clerk of Court is directed to provide CD copies of the oral argument proceedings in these appeals for the purchase. The $26.00 purchase price required by the Court of Appeals Miscellaneous Fee Schedule, 26 U.S.C. 1913, may be paid in cash or by check payable to U.S. Court of Appeals, 11th Circuit .... JFD, FMH and SM [11-11021, 11-11067]
06/08/2011	Oral argument held. Oral Argument participants were Neal Kumar Katyal for Appellants United States Department of Labor, et al., Michael Anthony Carvin for Appellees National Federation of Independent Business, et al., and Paul D. Clement for Appellees State of Florida and State of Utah, et al. in 11-11021. [11-11021, 11-11067]

06/21/2011	Supplemental Authority filed by Appellees Kaj Ahlburg and Mary Brown in 11-11021, Appellee Mary Brown in 11-11067. Service date: 06/17/2011 US mail - Attorney for Appellants: Bondy, Casey, Clement, Grossman, Jacquot, Kaersvang, Kennedy, Makar, Osterhaus, Rivkin, Winship. [11-11021, 11-11067]
07/07/2011	Supplemental Authority filed by Appellant United States Department of Health and Human Services in 11-11021. Service date: 07/06/2011 email - Attorney for Appellees: Clement, Katsas. [11-11021, 11-11067]
07/13/2011	Response to Supplemental Authority (28J) filed by Appellee Kaj Ahlburg in 11-11021, Appellee Mary Brown in 11-11067. Service date: 07/12/2011 US mail - Attorney for Appellants: Chaifetz, Clement. [11-11021, 11-11067]
08/09/2011	Supplemental Authority filed by Appellant SECRETARY OF THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES in 11-11021. Service date: 08/08/2011 US mail - Attorney for Appellees: Clement, Osterhaus, Rivkin. [11-11021, 11-11067]
08/12/2011	Opinion issued by court as to Appellants SECRETARY OF THE U.

S. DEPARTMENT OF HEALTH & HUMAN SERVICES, Secretary, U.S. Department of Labor, Secretary, US Department of Treasury, U.S. Department of Labor, US Department of Treasury and United States Department of Health and Human Services in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. Decision: Affirmed in part and Reversed in part. Opinion type: Published. Opinion method: Signed. [11-11021, 11-11067]

08/12/2011	Judgment entered as to Appellant SECRETARY OF THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES etc., in 11-11021. [11-11021, 11-11067]

* * *

09/28/2011	Notice of Writ of Certiorari filed as to Appellant United States Department of Health and Human Services. SC# 11-398.
09/28/2011	Notice of Writ of Certiorari filed as to Appellee National Federation of Independent Business. SC# 11-393.
10/03/2011	MOTION to stay mandate filed by Appellee United States Department of Health and Human Services in 11-11067. Motion is Unopposed [6398537-1] [11-11021, 11-11067]

* * *

10/05/2011	ORDER: On Oct. 4, 2011, the parties filed a joint mot to stay the issuance of the mandate ... Accordingly, on or before Noon, Eastern Standard Time on Wednesday, Oct.12, 2011, the parties are directed to jointly submit in writing to the court the reasons why they contend there is good cause for a stay (see file for complete text). JFD [11-11021, 11-11067]
10/11/2011	Response pursuant to court order of 10/05/2011 filed by Dana Kaersvang for U.S. Department of Labor, United States Department of Health and Human Services and US Department of Treasury in 11-11067, SKIP) [11-11021, 11-11067]
10/13/2011	ORDER: Motion to stay mandate filed

	by Appellee United States Department of Health and Human Services is DENIED [6398537-2] JFD, FMH and SM [11-11021, 11-11067]
10/24/2011	Mandate issued as to Appellants Secretary U.S. Department of Health and Human Services, Secretary, U.S. Department of Labor, Secretary, US Department of Treasury, U.S. Department of Labor, US Department of Treasury and United States Department of Health and Human Services in 11-11021, Appellants Terry E. Branstad, Commonwealth of Pennsylvania, State of Alabama, State of Alaska, State of Arizona, State of Colorado, State of Florida, State of Georgia, State of Idaho, State of Indiana, State of Kansas, State of Louisiana, State of Maine, State of Michigan, State of Mississippi, State of Nebraska, State of Nevada, State of North Dakota, State of Ohio, State of South Carolina, State of South Dakota, State of Texas, State of Utah, State of Washington, State of Wisconsin and State of Wyoming in 11-11067. [11-11021, 11-11067]

* * *

RELEVANT DOCKET ENTRIES

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF FLORIDA
(Pensacola)

Civil Docket for Case No.
3:10-cv-00091-RV-EMT

STATE OF FLORIDA, *et al.* v. U.S. DEP'T OF HEALTH & HUMAN SERVS., *et al.*

Date Filed	#	Document
03/23/2010	1	COMPLAINT against TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY filed by STATE OF FLORIDA - Filing Fee $350, Receipt Number: 1129-1533627) (WINSHIP, BLAINE) **Modified on 3/23/2010 to correct "docket text" (laj). (Entered: 03/23/2010)
		* * *
3/24/2010	3	Summons Issued as to

		TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY, U.S. Attorney and U.S. Attorney General. (krb) (Entered: 03/24/2010)
3/29/2010	4	NOTICE OF HEARING. Rule 16 Scheduling Conference set for 4/14/2010 09:00 AM in U.S. Courthouse Pensacola before SENIOR JUDGE ROGER VINSON. (lcu) (Entered: 03/29/2010)

* * *

4/14/2010	24	Minute Entry for proceedings held before SENIOR JUDGE ROGER VINSON: Scheduling Conference held on 4/14/2010. Scheduling Order to be entered. (Court Reporter Donna Boland.) (jrm) (Entered: 04/14/2010)

* * *

4/14/2010	26	FINAL SCHEDULING ORDER re 24 Scheduling Conference. Plaintiffs date for filing an

		amended complaint: 5/14/10. Defendants' date for filing a motion to dismiss: 6/16/10. Plaintiffs' date for filing a brief in opposition to motion to dismiss: 8/6/10. Defendants' date for filing a reply to Plaintiffs' opposition brief: 8/27/10. Oral argument on Defendants' motion to dismiss: 9/14/10 at 9:00 AM. Discovery deadline: 9/14/10. Signed by SENIOR JUDGE ROGER VINSON on 4/14/10. (tdg) (Entered: 04/14/2010)
4/14/2010	27	Redacted Notice and MOTION for Reconsideration or MOTION (titled Request) for Certification for Interlocutory Appeal – Re: 18 Order. (laj) Modified on 4/23/2010 (jrm). (Entered: 04/15/2010)

* * *

5/13/2010	41	SUMMONS Returned Executed by STATE OF WASHINGTON, STATE OF ALABAMA, STATE OF SOUTH CAROLINA, STATE OF FLORIDA, STATE OF SOUTH DAKOTA, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF COLORADO, STATE OF IDAHO, STATE OF

		MICHIGAN, STATEOF TEXAS, COMMONWEALTH OF PENNSYLVANIA, STATE OF UTAH. TIMOTHY F GEITHNER served on 4/12/2010, answer due 5/3/2010; KATHLEEN SEBELIUS served on 3/29/2010, answer due 4/19/2010; HILDA L SOLIS served on 3/29/2010, answer due 5/3/2010; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES served on 3/29/2010, answer due 5/3/2010; UNITED STATES DEPARTMENT OF LABOR served on 4/2/2010, answer due 5/3/2010; UNITED STATES DEPARTMENT OF THE TREASURY served on 4/12/2010, answer due 5/3/2010. (Attachments: # 1 Exhibit "A" Return of Service of HHS and H. Solis, # 2 Exhibit "B" Return of Service of Treasury and T. Geithner, # 3 Exhibit "C" Return of Service of Labor and H. Solis, # 4 Exhibit "D" return of Service of Attorney General E. Holder) (WINSHIP, BLAINE) (Entered: 05/13/2010)
5/14/2010	42	First AMENDED COMPLAINT by and through Sonny Perdue,

Governor of the State of Georgia, State of Alaska, by and through Daniel S. Sullivan, Attorney General of the State of Alaska, National Federation of Independent Business, a California Nonprofit Mutual Benefit Corporation, State of Nevada, by and through Jim Gibbons, Governor of the State of Nevada, State of North Dakota, by and through Wayne Stenejhem, Attorney General of the State of North Dakota, State of Indiana, by and through Gregory F. Zoeller, Attorney General, State of Mississippi, by and through Haley Barbour, Governor of the State of Mississippi, Kaj Ahlburg, State of Arizona, by and through Janice K. Brewer, Governor of the State of Arizona, Mary Brown, filed by STATE OF WASHINGTON, STATE OF ALABAMA, STATE OF SOUTH CAROLINA, STATE OF FLORIDA, STATE OF SOUTH DAKOTA, STATE OF LOUISIANA, STATE OF NEBRASKA, STATE OF COLORADO, STATE OF IDAHO, STATE OF MICHIGAN, STATE OF

		TEXAS, COMMONWEALTH OF PENNSYLVANIA, STATE OF UTAH (WINSHIP, BLAINE) Modified on 5/14/2010 to clean up text (djb). (Entered: 05/14/2010)

* * *

6/16/2010	55	MOTION to Dismiss by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Internal deadline for referral to judge if response not filed earlier: 7/6/2010). (Attachments: # 1 Memorandum in Support) (BECKENHAUER, ERIC) (Entered: 06/16/2010)
6/17/2010	56	NOTICE Errata by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES

		DEPARTMENT OF THE TREASURY re 55 MOTION to Dismiss (Attachments: # 1 Memorandum in Support of 55 Defendants' Motion to Dismiss) (BECKENHAUER, ERIC) (Entered: 06/17/2010)

* * *

8/06/2010	68	RESPONSE in Opposition re 55 MOTION to Dismiss filed by STATE OF FLORIDA, et al (all plaintiffs). (WINSHIP, BLAINE) **Modified on 8/6/2010 to create linkage for filers. (laj). (Entered: 08/06/2010)

* * *

8/27/2010	74	REPLY to Response to Motion re 55 MOTION to Dismiss filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (KENNEDY, BRIAN) (Entered: 08/27/2010)

* * *

9/15/2010	76	AMENDED FINAL SCHEDULING ORDER – Re: 26 Order – A) I will enter my written Order on the Dfts' 55 Motion to Dismiss on or before 10/14/2010. Assuming the case survives dismissal in whole or in part, the parties have until 11/4/2010 in which to move for summary judgment (and the Dfts may file their answer at the same time); the opposing party will have until 11/23/2010 to respond; and the moving party will have until 12/6/2010 to file any Reply. B) As provided in the original Final Scheduling Order, the briefing with regard to the motions discussed above will be limited to (50) pages for the initial and responsive briefs, and (25) pages for reply briefs. C) Hearing and oral argument on the motion(s) for summary judgment will held on Thursday, 12/16/2010 @ 9:00 AM (CST). Both sides will be allowed (1) hour for argument. Signed by SENIOR JUDGE ROGER VINSON on 9/15/2010. (laj) (Entered: 09/16/2010)

* * *

10/08/2010	78	NOTICE of Supplemental

		Authority by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Exhibit Thomas More Law Center v. Obama, No. 10–CV–11156 (E.D. Mich. Oct. 7, 2010)) (BECKENHAUER, ERIC) (Entered: 10/08/2010)
10/14/2010	79	ORDER AND MEMORANDUM OPINION – The Dfts' 55 Motion to Dismiss is GRANTED w/respect to Counts Two, Five, and Six, and those counts are hereby DISMISSED. The Motion is DENIED w/respect to Counts One and Four, Count Three is also DISMISSED, as Moot. The case will continue as to Counts One and Four pursuant to the Scheduling Order previously entered. Signed by SENIOR JUDGE ROGER VINSON on 10/14/2010. (laj) (Entered: 10/14/2010)
11/04/2010	80	MOTION for Summary

		Judgment by PLAINTIFF STATES. (Internal deadline for referral to judge if response not filed earlier: 11/22/2010). (Attachments: # 1 Memorandum of Law, # 2 Statement of Material Facts, # 3 Exhibits Volume I, # 4 Exhibits Volume II, # 5 Exhibits Volume III, # 6 Exhibits Volume IV) (tdg) (Additional attachment(s) added on 11/4/2010: # 7 Exhibits Volume V.1 (35, 36), # 8 Exhibits Volume V.2 (37,38), # 9 Exhibits Volume V.3 (39,40)) (tdg). (Entered: 11/04/2010)
11/04/2010	81	ANSWER to Complaint 42 Amended Complaint by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) (Entered: 11/04/2010)
11/04/2010	82	MOTION for Summary Judgment by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS,

		UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Internal deadline for referral to judge if response not filed earlier: 11/22/2010). (Attachments: # 1 Memorandum in Support, # 2 Statement of Facts) (BECKENHAUER, ERIC) (Entered: 11/04/2010)
11/05/2010	83	NOTICE Errata re Exhibits in support of 82 Defendants' Motion for Summary Judgment by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY (Attachments: # 1 Table of Exhibits, # 2 Exhibit 1, # 3 Exhibit 2, # 4 Exhibit 3, # 5 Exhibit 4, # 6 Exhibit 5, # 7 Exhibit 6, # 8 Exhibit 7, # 9 Exhibit 8, # 10 Exhibit 9, # 11 Exhibit 10, # 12 Exhibit 11, #

		13Exhibit 12, # 14 Exhibit 13, # 15 Exhibit 14, # 16 Exhibit 15, # 17 Exhibit 16, # 18 Exhibit 17, # 19 Exhibit 18, # 20 Exhibit 19, # 21 Exhibit 20, # 22 Exhibit 21, # 23 Exhibit 22, # 24 Exhibit 23, # 25 Exhibit 24, # 26 Exhibit 25, # 27 Exhibit 26, # 28 Exhibit 27, # 29 Exhibit 28, # 30 Exhibit 29, # 31 Exhibit 30, # 32 Exhibit 31, # 33 Exhibit 32, # 34 Exhibit 33, # 35 Exhibit 34, # 36 Exhibit 35, # 37 Exhibit 36, # 38 Exhibit 37, # 39 Exhibit 38, # 40 Exhibit 39, # 41 Exhibit 40, # 42 Exhibit 41, # 43 Exhibit 42, # 44 Exhibit 43) (BECKENHAUER, ERIC) (Entered: 11/05/2010)
11/08/2010	85	NOTICE of Filing by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF

		MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON (Attachments: # 1 Plaintiffs Statement of Position on Motions for Leave to File Briefs as Amici Curiae) (WINSHIP, BLAINE) (Entered: 11/08/2010)

* * *

11/23/2010	135	PLAINTIFFS MEMORANDUM in Opposition to Defendants' Motion for Summary Judgment 82 filed by STATE OF FLORIDA. (Attachments: # 1 Supplemental Appendix) (tdg) (Entered: 11/23/2010)
11/23/2010	136	PLAINTIFFS' RESPONSE to Defendants' Statement of Facts As to Which There Is No Genuine Issue 82 filed by STATE OF FLORIDA. (tdg) (Entered: 11/23/2010)
11/23/2010	137	MEMORANDUM in Opposition re 80 MOTION for Summary Judgment filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS,

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (Attachments: # 1 Response to Plaintiffs' Statement of Facts) (BECKENHAUER, ERIC) (Entered: 11/23/2010)

* * *

12/06/2010 138 REPLY to Response to Motion re 80 MOTION for Summary Judgment filed by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OFALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH

		DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON. (WINSHIP, BLAINE) (Entered: 12/06/2010)
12/06/2010	139	REPLY to Response to Motion re 82 MOTION for Summary Judgment filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) (Entered: 12/06/2010)

* * *

12/14/2010	143	NOTICE of Supplemental Authority by KAJ AHLBURG, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF

		FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF LOUISIANA, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON (Attachments: # 1 Exhibit Virginia Order Granting Summary Judgment) (WINSHIP, BLAINE) (Entered: 12/14/2010)
		* * *
12/16/2010	145	Minute Entry for proceedings held before SENIOR JUDGE ROGER VINSON: oral arguments as to parties' motions for summary judgment held on 12/16/2010. (Court Reporter Donna Boland.) (jmd) (Entered: 12/16/2010)
		* * *
1/19/2011	149	ORDER – The plaintiffs' motion for leave to file a second amended complaint (doc. 147) is hereby GRANTED, and the new complaint will be deemed filed

		as of this date, as will the defendants' previously–filed answer. Signed by SENIOR JUDGE ROGER VINSON on 1/19/2011. (djb) (Entered: 01/19/2011)
1/31/2011	150	ORDER GRANTING SUMMARY JUDGMENT – For all the reasons stated and pursuant to Rule 56 of the Federal Rules of Civil Procedure, the plaintiffs motion for summary judgment (doc. 80) is hereby GRANTED as to its request for declaratory relief on Count I of the Second Amended Complaint, and DENIED as to its request for injunctive relief; and the defendants' motion for summary judgment (doc. 82) is hereby GRANTED on Count IV of the Second Amended Complaint. The respective cross–motions are each DENIED. In accordance with Rule 57 of the Federal Rules of Civil Procedure and Title 28, United States Code, Section 2201(a), a Declaratory Judgment shall be entered separately, declaring "The Patient Protection and Affordable Care Act" unconstitutional. Signed by

		SENIOR JUDGE ROGER VINSON on 1/31/2011. (djb) Modified on 1/31/2011 (djb). (Entered: 01/31/2011)
1/31/2011	151	FINAL SUMMARY DECLARATORY JUDGMENT. It is hereby DECLARED, ADJUDGED, and DECREED that The Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029 (2010), is unconstitutional. Signed by SENIOR JUDGE ROGER VINSON on 1/31/2011. (djb) (Entered: 01/31/2011)

* * *

2/17/2011	156	MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment, by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE

		TREASURY. (BECKENHAUER, ERIC) (Entered: 02/17/2011)
2/18/2011	157	ORDER DIRECTING EXPEDITED FILING re 156 MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment. From the date of this Order, the plaintiffs shall have 3 business days in which to file their response in opposition to the defendants' motion. If the defendants wish to file a reply to that response, they shall also have 3 business days from the date the response is filed. (Internal deadline for referral to judge if response not filed on: 2/23/2011.) Signed by SENIOR JUDGE ROGER VINSON on February 18, 2011. (tl) Modified on 2/22/2011 to clarify text. (tl) (Entered: 02/18/2011)
2/23/2011	158	MEMORANDUM in Opposition re 156 MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment, filed by KAJ AHLBURG, TERRY E BRANSTAD, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF

		INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF KANSAS, STATE OF LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF WYOMING. (WINSHIP, BLAINE) Modified on 2/24/2011 to clarify text (tl). (Entered: 02/23/2011)

* * *

2/28/2011	164	REPLY to 158 Response to 156 MOTION To Clarify re 150 Order on Motion for Summary Judgment, 151 Judgment, filed by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS,

		HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (BECKENHAUER, ERIC) Modified on 3/1/2011 to clarify text, create link. (tl) (Entered: 02/28/2011)

* * *

3/03/2011	167	ORDER. The defendants' motion to clarify 156 is GRANTED. To the extent that motion is construed as a motion to stay, it is also GRANTED, and the summary declaratory judgment entered in this case is STAYED pending appeal, conditioned upon the defendants filing their notice of appeal within seven (7) calendar days of this order and seeking an expedited appellate review. Signed by SENIOR JUDGE ROGER VINSON on 3/3/11. (tdg) (Entered: 03/03/2011)

* * *

3/08/2011	169	NOTICE OF APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary

		Judgment, 151 Judgment, 167 Order, by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. ((BECKENHAUER, ERIC) (Entered: 03/08/2011)

* * *

3/10/2011	173	NOTICE OF CROSS APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary Judgment, 151 Judgment, by KAJ AHLBURG, TERRY E BRANSTAD, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF KANSAS, STATE OF

LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF WYOMING. Filing fee $455, receipt number 1129–1831078. Appeal Record due by 3/8/2011. (WINSHIP, BLAINE) (Entered: 03/10/2011)

* * *

3/11/2011 177 USCA Case Number 11–11021–HH for 169 NOTICE OF APPEAL by TIMOTHY F GEITHNER, KATHLEEN SEBELIUS, HILDA L SOLIS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES DEPARTMENT OF LABOR, UNITED STATES DEPARTMENT OF THE TREASURY. (tl) (Entered: 03/11/2011)

* * *

3/11/2011	179	AMENDED NOTICE OF CROSS APPEAL as to 79 Order on Motion to Dismiss, 150 Order on Motion for Summary Judgment, 151 Judgment, by KAJ AHLBURG, TERRY E BRANSTAD, MARY BROWN, COMMONWEALTH OF PENNSYLVANIA, NATIONAL FEDERATION OF INDEPENDENT BUSINESS, STATE OF ALABAMA, STATE OF ALASKA, STATE OF ARIZONA, STATE OF COLORADO, STATE OF FLORIDA, STATE OF GEORGIA, STATE OF IDAHO, STATE OF INDIANA, STATE OF KANSAS, STATE OF LOUISIANA, STATE OF MAINE, STATE OF MICHIGAN, STATE OF MISSISSIPPI, STATE OF NEBRASKA, STATE OF NEVADA, STATE OF NORTH DAKOTA, STATE OF OHIO, STATE OF SOUTH CAROLINA, STATE OF SOUTH DAKOTA, STATE OF TEXAS, STATE OF UTAH, STATE OF WASHINGTON, STATE OF WISCONSIN, STATE OF

WYOMING. Appeal Record due by 3/8/2011. (WINSHIP, BLAINE) Modified on 3/14/2011 to clarify text. (tl) (Entered: 03/11/2011)

* * *

4/04/2011 192 ORDER of USCA as to 169 Notice of Appeal #11–11021–HH, 173 Notice of Cross Appeal #11–11067–HH: Petition for Initial Hearing En Banc is Denied. Motion to expedite this appeal is Granted in part. Oral argument shall be heard on Wednesday, June 8, 2011, at 9:30 A.M. in Atlanta, GA. (tll) (Entered: 04/08/2011)

* * *

10/25/2011 196 MANDATE of USCA AFFIRMING in part and REVERSING in part 169 Notice of Appeal and 173 Notice of Cross Appeal. (USCA Appeal #'s 11-11021-HH; 11-11067-HH) (kvg) (Entered: 10/25/2011)

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 01/18/11
DOCUMENT NO.: 148

SECOND AMENDED COMPLAINT

Pursuant to Rule 15(a), Federal Rules of Civil Procedure, Plaintiffs file this Second Amended Complaint against Defendants and state:

NATURE OF THE ACTION

1. This is an action seeking declaratory and injunctive relief from the "Patient Protection and Affordable Care Act," P.L. 111-148, as amended by the "Health Care and Education Reconciliation Act of 2010," P.L. 111-152 (collectively the Act). The Act's mandate that all citizens and legal residents of the United States maintain qualifying healthcare coverage or pay a penalty (individual mandate) is an unprecedented encroachment on the sovereignty of

the Plaintiff States and on the rights of their citizens, including members of Plaintiff National Federation of Independent Business (NFIB) and individual Plaintiffs Mary Brown and Kaj Ahlburg. By imposing such a mandate, the Act: exceeds the powers of the United States under Article I of the Constitution, particularly the Commerce Clause; violates the Ninth and Tenth Amendments and the Constitution's principles of federalism and dual sovereignty; and violates the Fifth Amendment's Due Process Clause. In the alternative, if the penalty required under the Act is a tax, it constitutes an unlawful capitation or direct tax in violation of Article I, sections 2 and 9 of the Constitution.

2. The Act further violates the Constitution by forcing the Plaintiff States to operate a wholly refashioned Medicaid program. The Act converts Medicaid from a federal-State partnership to provide a safety net for the needy into a federally-imposed universal healthcare regime, in which the discretion of the Plaintiff States has been removed and new requirements and expenses forced upon them in derogation of their sovereignty. In so doing, the Act violates the Ninth and Tenth Amendments and the Constitution's principles of federalism.

3. Plaintiffs seek declaratory and injunctive relief against the Act's operation in order to avoid an unprecedented and unconstitutional intrusion by the federal government into the private affairs of every American and to preserve Plaintiff States' respective sovereignty, as guaranteed by the Constitution.

JURISDICTION AND VENUE

4. The Court has subject-matter jurisdiction pursuant to 28 U.S.C. § 1331 because this action arises under the Constitution and laws of the United States and further has jurisdiction to render declaratory relief under 28 U.S.C. § 2201.

5. Venue is proper in this district pursuant to 28 U.S.C. § 1391(e)(3) because no real property is involved, the district is situated in Florida, and the defendants are agencies of the United States or officers thereof acting in their official capacity.

PARTIES

6. The State of Florida, by and through Pam Bondi, Attorney General of Florida, is a sovereign State in the United States of America.

7. The State of South Carolina, by and through Alan Wilson, Attorney General of South Carolina, is a sovereign State in the United States of America.

8. The State of Nebraska, by and through Jon Bruning, Attorney General of Nebraska, is a sovereign State in the United States of America.

9. The State of Texas, by and through Greg Abbott, Attorney General of Texas, is a sovereign State in the United States of America.

10. The State of Utah, by and through Mark L. Shurtleff, Attorney General of Utah, is a sovereign State in the United States of America.

11. The State of Alabama, by and through Luther Strange, Attorney General of Alabama, is a sovereign State in the United States of America.

12. The State of Louisiana, by and through James D. "Buddy" Caldwell, Attorney General of Louisiana, is a sovereign State in the United States of America.

13. Bill Schuette, Attorney General of Michigan, is bringing this action on behalf of the People of Michigan under Mich. Comp. Law § 14.28, which provides that the Michigan Attorney General may "appear for the people of [Michigan] in any other court or tribunal, in any cause or matter, civil or criminal, in which the people of [Michigan] may be a party or interested." Under Michigan's constitution, the people are sovereign. Mich. Const. art. I, § 1 ("All political power is inherent in the people. Government is instituted for their equal benefit, security, and protection.").

14. The State of Colorado, by and through John W. Suthers, Attorney General of Colorado, is a sovereign State in the United States of America.

15. The Commonwealth of Pennsylvania, by and through Thomas W. Corbett, Jr., Governor of Pennsylvania, and William H. Ryan, Jr., Acting Attorney General of Pennsylvania, is a sovereign State in the United States of America.

16. The State of Washington, by and through Robert A. McKenna, Attorney General of Washington, is a sovereign State in the United States of America.

17. The State of Idaho, by and through Lawrence G. Wasden, Attorney General of Idaho, is a sovereign State in the United States of America.

18. The State of South Dakota, by and through Marty J. Jackley, Attorney General of South Dakota, is a sovereign State in the United States of America.

19. The State of Indiana, by and through Gregory F. Zoeller, Attorney General of Indiana, is a sovereign State in the United States of America.

20. The State of North Dakota, by and through Wayne Stenehjem, Attorney General of North Dakota, is a sovereign State in the United States of America.

21. The State of Mississippi, by and through Haley Barbour, Governor of Mississippi, is a sovereign State in the United States of America.

22. The State of Arizona, by and through Janice K. Brewer, Governor of Arizona, and Thomas C. Horne, Attorney General of the State of Arizona, is a sovereign State in the United States of America.

23. The State of Nevada, by and through Jim Gibbons, Governor of Nevada, is a sovereign State in the United States of America.

24. The State of Georgia, by and through Samuel S. Olens, Attorney General of Georgia, is a sovereign State in the United States of America.

25. The State of Alaska, by and through Daniel S. Sullivan, Attorney General of Alaska, is a sovereign State in the United States of America.

25A. The State of Ohio, by and through Michael DeWine, Attorney General of Ohio, is a sovereign State in the United States of America.

25B. The State of Kansas, by and through Derek Schmidt, Attorney General of Kansas, is a sovereign State in the United States of America.

25C. The State of Wyoming, by and through Matthew H. Mead, Governor of Wyoming, is a sovereign State in the United States of America.

25D. The State of Wisconsin, by and through J.B. Van Hollen, Attorney General of Wisconsin, is a sovereign State in the United States of America.

25E. The State of Maine, by and through William J. Schneider, Attorney General of Maine, is a sovereign State in the United States of America.

25F. Terry E. Branstad, Governor of Iowa, is bringing this action on behalf of the People of Iowa, a sovereign State in the United States of America.

26. The National Federation of Independent Business (NFIB), a California nonprofit mutual benefit corporation, is the nation's leading association of small businesses, including individual members, and has a presence in all 50 States and the District of Columbia. NFIB's mission is to promote and protect the rights of its members to own, operate, and earn success in their businesses, in accordance with lawfully imposed governmental requirements. The NFIB Small Business Legal Center is a nonprofit, public interest law firm established to provide legal resources and be the voice for small businesses in the nation's courts through representation on issues of public interest affecting small businesses. NFIB's members include individuals who object to: forced compliance with the Act's mandate that they obtain qualifying healthcare

insurance or pay a penalty; diversion of resources from their businesses that will result from complying with the mandate; and the Act's overreaching and unconstitutional encroachment on the States' sovereignty. NFIB joins in those objections on behalf of its members. NFIB's services to its members include providing information regarding legal and regulatory issues faced by small businesses, including individuals. NFIB will incur additional costs in assisting its members in understanding how the Act applies to them and affects their businesses.

27. Mary Brown is a citizen and resident of the State of Florida and a citizen of the United States. She is self-employed, operating Brown & Dockery, Inc., an automobile repair facility in Panama City, Florida, and is a member of NFIB. Ms. Brown has not had healthcare insurance for the last four years, and devotes her resources to maintaining her business and paying her employees. She does not qualify for Medicaid under the Act or Medicare and does not expect to qualify for them prior to the Act's individual mandate taking effect. Ms. Brown will be subject to the mandate and objects to being forced to comply with it, and objects to the Act's unconstitutional overreaching and its encroachment on the States' sovereignty.

28. Kaj Ahlburg is a citizen and resident of the State of Washington and a citizen of the United States. Mr. Ahlburg has not had healthcare insurance for more than six years, does not have healthcare insurance now, and has no intention or desire to have healthcare insurance in the future. Mr. Ahlburg is and reasonably expects to remain financially able to pay for his own healthcare

services if and as needed. He does not qualify for Medicaid under the Act or Medicare and does not expect to qualify for them prior to the Act's individual mandate taking effect. Mr. Ahlburg will be subject to the mandate and objects to being forced to comply with it, and objects to the Act's unconstitutional overreaching and its encroachment on the States' sovereignty. (Plaintiffs Brown and Ahlburg are referred to as the Individual Plaintiffs.)

29. The Department of Health and Human Services (HHS) is an agency of the United States, and is responsible for administration and enforcement of the Act, through its center for Medicare and Medicaid Services.

30. Kathleen Sebelius is Secretary of HHS, and is named as a party in her official capacity.

31. The Department of the Treasury (Treasury) is an agency of the United States, and is responsible for administration and enforcement of the Act.

32. Timothy F. Geithner is Secretary of the Treasury, and is named as a party in his official capacity.

33. The Department of Labor (DOL) is an agency of the United States, and is responsible for administration and enforcement of the Act.

34. Hilda L. Solis is Secretary of DOL, and is named as a party in her official capacity.

FACTUAL ALLEGATIONS

The Unprecedented and Unconstitutional Individual Mandate

35. The Act mandates that all persons who are citizens or legal residents of any State within the United States, including NFIB members and the Individual Plaintiffs, must have and maintain qualifying healthcare coverage, regardless of whether they wish to do so, to avoid having to pay a penalty. Many individuals, including NFIB members and the Individual Plaintiffs, will be forced to purchase the required coverage with their own assets, without contribution or subsidy from the federal government. If a person fails to maintain such coverage, the federal government will force that person to pay a penalty, the amount of which will be increased gradually through 2016, reaching 2.5 percent of household income or $695 per year (up to a maximum of three times that amount ($2,085)) per family, whichever is greater. After 2016, the penalty will increase annually based on a cost-of-living adjustment.

36. Exemptions to the penalty apply for individuals with certain religious objections, individuals who belong to certain faith-based healthcare cooperative organizations, American Indians, persons without coverage for less than three months, undocumented immigrants, incarcerated individuals, persons for whom the lowest cost plan option exceeds 8 percent of income, individuals with incomes below the tax filing threshold, and persons with financial hardships. Millions of individuals will

be forced to choose between having qualified coverage and paying the penalty.

37. Congress never before has imposed a mandate that all citizens buy something—in this case health insurance—or pay a penalty. According to the non-partisan Congressional Budget Office (CBO), "the imposition of an individual mandate [to buy health insurance] . . . would be unprecedented. The government has never required people to buy any good or service as a condition of lawful residence in the United States." THE BUDGETARY TREATMENT OF AN INDIVIDUAL MANDATE TO BUY HEALTH INSURANCE, CBO MEMORANDUM (August 1994), http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf (last visited May 11, 2010). The CBO added that an individual mandate could "transform the purchase of health insurance from an essentially voluntary private transaction into a compulsory activity mandated by law." *Id.*

38. Congress lacks the constitutional authority to enact the individual mandate. The Constitution limits Congress's authority to the specific powers enumerated in Article I, and thus does not grant unlimited authority to Congress. None of Congress's enumerated powers includes the authority to force every American to buy a good or service on the private market or face a penalty. For the first time, Congress under the Act is attempting to regulate and penalize Americans for choosing not to engage in economic activity. If Congress can do this much, there will be virtually no sphere of private decision-making beyond the reach of federal power.

Medicaid Program Prior to the Act

39. Medicaid was established by Title XIX of the Social Security Act of 1965, 42 U.S.C. §§ 1396 *et seq.*, as the nation's major healthcare program for low-income persons. The States and the federal government have funded each participating State's Medicaid program jointly.

40. From the beginning of Medicaid until passage of the Act, the States were given considerable discretion to implement and operate their respective Medicaid programs in accordance with State-specific designs regarding eligibility, enrollment, and administration, so long as the programs met broad federal requirements.

41. At the outset of Medicaid, the States were free to opt in and establish their own State health or welfare plans or to provide no benefits at all. None of the Plaintiff States agreed to become a Medicaid partner of the federal government with an expectation that: a) the terms of its participation would be altered significantly; b) the federal government would increase significantly its own control and reduce significantly that State's discretion over the Medicaid program; c) the federal government would alter the program's requirements to expand eligibility for enrollment beyond the State's ability to fund its participation; d) the federal government would alter the program from requiring that States pay for healthcare services to requiring that States provide such services; or e) the federal government would exercise its control over Medicaid terms and eligibility as part of a coercive scheme to

force all citizens and residents of the States to have healthcare coverage.

The Act's Injurious Impact on the Federal-State Healthcare Partnership

42. The Act greatly alters the federal-State relationship, to the detriment of the Plaintiff States, with respect to Medicaid programs, their insurance regulatory role, and healthcare coverage generally.

43. The Act transforms Medicaid from federal-State partnerships into a broad federally-controlled program that deprives the States of the ability to define healthcare program eligibility and attributes, and eliminates States' historic flexibility to make costsaving and other adjustments to their respective Medicaid programs. The Act also sets new increased Medicaid rates for primary-care practitioners' reimbursements, which States must substantially fund, and changes the manner in which drug rebates are allocated between the federal government and States in a manner that financially benefits the federal government at the States' expense.

44. The Act requires each State to expand massively its Medicaid program and to create a statewide exchange, which must be either a State governmental agency or a nonprofit entity established by the State for this purpose, through which the citizens and residents of that State can purchase healthcare insurance. If a State does not satisfy federal requirements to progress toward creation of an intrastate insurance exchange between now and the end of 2012, or chooses not to operate an exchange, the federal government (or its contractor) will establish and administer an

intrastate exchange within that State. This action would displace State authority over a substantial segment of intrastate insurance regulation (e.g., licensing and regulation of intrastate insurers, plans, quality ratings, coordination with Medicaid and other State programs, and marketing) that the States have always possessed under the police powers provided in the Constitution, and subject the States to possible exchange-related penalties.

45. Participation in the Act will force the States to expand their Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level. The federal government will fund much of the cost initially, but States' coverage burdens will increase significantly after 2016, both in actual dollars and in proportion to the contributions of the federal government.

46. The Act further requires that States provide healthcare services to enrollees, a significant new obligation that goes far beyond the States' pre-Act responsibility for funding healthcare services under their respective Medicaid programs. This obligation will expose the States to significant increased litigation risks and costs.

47. The federal government will not provide full funding or resources to the States to administer the Act. Each State must oversee the newly-created intrastate insurance market by instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes. Each State also must enroll all of the newly-eligible Medicaid beneficiaries (many of whom will be subject to a penalty if they fail to

enroll), coordinate enrollment with the new intrastate insurance exchange, and implement other specified changes. The Act further requires each State to establish a reinsurance program by 2014, to administer a premium review process, and to cover costs associated with State-mandated insurance benefit requirements that States previously could impose without assuming a cost.

48. In addition, the Act imposes new requirements on the Plaintiff States that interfere with their ability to perform governmental functions. Effective in 2014, the Plaintiff States, as large employers, must automatically enroll employees working 30 or more hours a week into health insurance plans, without regard for current State practice, policy preferences, or financial constraints. The Act's individual mandate effectively will force many more State employees into State insurance plans than the Plaintiff States now allow, at a significant added cost to the States. Moreover, the States will be subject to substantial penalties and taxes prescribed by the Act, at a cost of thousands of dollars per employee, for State employees who obtain subsidized insurance from an exchange instead of from a State plan, or if the State plan offers coverage that is either too little or too generous as determined by the federal government. New tax reporting requirements prescribed by the Act also will burden the Plaintiff States' ability to source goods and services as necessary to carry out governmental functions.

The Act's Injurious Impact on Plaintiffs

49. The Act will have a profound and injurious impact on all Plaintiff States. Florida's circumstances, as described below, are not identical to the circumstances in all of the Plaintiff States, but fairly represent the nature of the burdens the Act imposes on the Plaintiff States.

50. Based on United States Census Bureau statistics from 2008, Florida has 3,641,933 uninsured persons living in the State. Of those persons, 1,259,378 are below 133 percent of the federal poverty line; therefore, the Act requires that Florida add them to its Medicaid rolls.

51. Even before passage of the Act, the Medicaid program imposed a heavy cost on Florida, consuming 26 percent of its annual budget. For fiscal year 2009-2010 alone, Florida will spend more than $18 billion on Medicaid, servicing more than 2.7 million persons. Florida's Medicaid contributions and burdens, from the implementation of its Medicaid program in 1970 to the present, have gradually increased to the point where it would be infeasible for Florida to cease its participation in Medicaid before the Act takes effect and make alternate arrangements for a traditional Medicaid-like program.

52. The federal government currently contributes 67.64 percent of every dollar Florida spends on Medicaid, a percentage that is temporarily inflated because of federal stimulus outlays. Under the current pre-Act program, after this year, the percentage of Florida's Medicaid expenses covered by the federal government would decline, and by 2011

would reach 55.45 percent, a level that is closer to the recent average. The federal government's contribution under the Act, though providing more aid for newly-eligible persons, will not fully compensate Florida for the dramatic increase to its Medicaid rolls, increased reimbursement rates for primary-care practitioners, and other substantial costs that it must bear under the Act.

53. Florida's Agency for Health Care Administration (AHCA) estimates that at least 80 percent of persons who have some form of health insurance but fall below 133 percent of the federal poverty level will drop their current plans and enroll in Medicaid, because they are newly eligible under the Act. The Act does not provide full funding for the States' cost of covering these already-covered persons. These persons represent a significant additional cost to Florida under the Act.

54. The Act also makes a large new class of persons eligible for Medicaid in Florida. Prior to passage of the Act, only certain specified low-income individuals and families qualified for Medicaid. Moreover, the qualifying income level set by Florida was generally much lower than the level of 133 percent of the federal poverty line set by the federal government under the Act. Now, Florida also must add to its Medicaid rolls every childless adult whose income falls below 133 percent of the federal poverty line, consistent with the Act's fundamental change in Medicaid from a federal-State partnership to provide a safety net for the needy into a federally-imposed regime for universal healthcare coverage.

55. Prior to passage of the Act, AHCA was Florida's designated State Medicaid agency tasked with developing and carrying out policies related to the Medicaid program. The Act will strip away much of the State's authority to establish and execute policies, transferring that authority to the federal government. Indeed, the Act renders AHCA and other Florida agencies mere arms of the federal government and commandeers and forces AHCA employees to administer what now is essentially a federal universal healthcare program.

56. AHCA projects a cost to Florida in the billions of dollars between now and 2019, stemming from Medicaid-related portions of the Act. The annual cost will continue to grow in succeeding years. AHCA's projections, moreover, understate the Act's adverse impact on Florida. They do not include estimated costs to be borne by Florida to administer the Act or to prepare for the Act's implementation. Such costs will include hiring and training new staff, creating new information technology infrastructures, developing an adequate provider base, creating a scheme for accountability and quality assurance, and incurring many other expenses.

57. The Act requires that Florida immediately begin to devote funds and other resources to implement sweeping changes across multiple agencies of government. Such implementation burdens include, but are not limited to: a) enforcing the Act's immediately-effective terms; b) determining gaps between current resources in State government and the Act's requirements; c) evaluating infrastructure to consider how new programs and substantial expansion of existing

programs will be implemented (e.g., new agencies, offices, etc.); d) developing a strategic plan and coordinating common issues across State agencies; e) initiating legislative and regulatory processes, while at the same time monitoring and engaging the substantial federal regulatory processes to ensure that State interests are protected; f) electing whether to participate in optional programs set forth in the Act; g) satisfying the Act's interim targets; and h) developing communications structure and plan to disseminate new information regarding changes brought about by the Act to the many affected persons and entities.

58. The Act further requires Florida to enroll in healthcare insurance plans categories of State employees not previously covered by State-funded healthcare insurance plans. The Act subjects the State to penalties, depending upon the coverage decisions made by its employees, and limits the State's ability to determine coverage. If the State's plan for its employees is deemed inadequate by the federal government, the State will be subject to penalties. If the State's plan is deemed too generous or expansive by the federal government, the State will be subject to a distinct federal tax liability.

59. The Act also requires that Florida be responsible for providing healthcare services for all Medicaid enrollees in the expanded program, a significant change from Florida's responsibility for providing payment for such services. This added responsibility and resulting new legal liabilities further contribute to the Act's substantial and costly impact on Florida's fisc, and will force the State to

ignore other critical needs, including education, corrections, law enforcement, and more.

60. In sum, as demonstrated through the effects on Florida, the Act infringes on the Plaintiff States' constitutional status as sovereigns, entitled to cooperate with but not to be controlled by the federal government under the Medicaid program.

61. In addition, the Act will have a profound and injurious impact on the Plaintiff States' citizens and residents, a significant number of whom are or will be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty.

62. The Act further will have a profound and injurious impact on NFIB's individual members and its uninsured small business owners, including Ms. Brown, who are and will continue to be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty. Because of the mandate, these members will be forced to divert resources from their business endeavors, or otherwise to reorder their economic circumstances, in order to obtain qualifying healthcare coverage, regardless of their own conclusions on whether or not obtaining and maintaining such coverage for themselves and their dependents is a worthwhile cost of doing business. The added costs of the mandate will threaten the members' ability to maintain their own, independent businesses.

63. An important service offered by NFIB to its membership is the provision of information and assistance regarding legal and regulatory compliance issues faced by small businesses, as well as questions involving healthcare insurance and

benefits. In order fully to serve the needs and interests of its membership, NFIB now will be forced to devote its own scarce resources to assisting members in understanding how the Act, including the mandate to obtain qualifying coverage or pay a penalty, applies to them, how it will affect their businesses, and what they must do to comply.

64. The Act also will injure Mr. Ahlburg, who will be subject to the Act's mandate to obtain qualifying healthcare coverage or pay a penalty. The Act's Requirements and Effects on the Plaintiff States Cannot Be Avoided

65. Plaintiff States cannot avoid the Act's requirements. Neither the Act nor current federal Medicaid provisions prescribe a mechanism for a State to opt out of the Act's new Medicaid requirements, to opt out of Medicaid generally, or to transition to another program that provides only traditional Medicaid services.

66. Moreover, if they were to end their longstanding participation in Medicaid, Plaintiff States would desert millions of their residents, leaving them without access to the healthcare services they have depended on for decades under Medicaid. Thus, Plaintiff States are forced to accept the harmful effects of the Act on their fiscs and their sovereignty.

67. Prior to passage of the Act, Medicaid and its corresponding law, regulations, guidance, policies, and framework had been well-established, subject to occasional limited modifications, for more than four decades. During that time, participating States developed their respective Medicaid programs in

reliance on Medicaid continuing to be a partnership with the federal government.

68. Presently, the Centers for Medicare and Medicaid (CMS), the federal agency with chief responsibility for administering Medicaid for the federal government, will terminate a State's federal funding for Medicaid unless the State complies with the Act's requirements. In addition, Medicaid requirements are linked to other federal programs, and the benefits of those programs to a State and its citizens and residents would be in jeopardy if the federal government were to terminate the State's participation in Medicaid.

CAUSES OF ACTION

COUNT ONE

UNCONSTITUTIONAL MANDATE THAT ALL INDIVIDUALS HAVE HEALTHCARE INSURANCE COVERAGE OR PAY A PENALTY

(Const. art. I & amend. IX, X)

69. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

70. The Act forces all Americans, including NFIB members and the Individual Plaintiffs, regardless of whether they want healthcare coverage, to obtain and maintain a federally-approved level of coverage or pay a penalty. The Act thus compels all Americans to perform an affirmative act or incur a penalty, simply on the basis that they exist and reside within any of the United States. In so doing, the Act purports to exercise the very type of general police power the

Constitution reserves to the States and denies to the federal government.

71. The Act is directed to a lack of, or failure to engage in, activity that is driven by the choices of individual Americans. Such inactivity by its nature cannot be deemed to be in commerce or to have such an effect on commerce, whether interstate or otherwise, as to be subject to Congress's powers under the Commerce Clause, Const. art. I, § 8. Nor does the Act regulate (directly or indirectly) any properly regulable interstate or foreign market or other commerce, any instrumentality of interstate or foreign commerce, or the actual flow of goods, services, and human beings among the States. As a result, the Act cannot be upheld under the Commerce Clause.

72. The Act infringes upon Plaintiff States' sovereign interests by coercing many persons to enroll in an expanded Medicaid program at a substantial cost to Plaintiff States, or to obtain coverage from intrastate exchanges that States must establish to avoid loss of substantial regulatory authority. The Act also denies Plaintiff States their sovereign ability to confer rights upon their citizens and residents to make healthcare decisions without government interference, including the decision not to participate in any healthcare insurance program or scheme, in violation of the Ninth and Tenth Amendments to the Constitution and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

73. The Act's penalty on uninsured persons unlawfully coerces persons to obtain healthcare

coverage without purposing to raise revenue and injures the Plaintiff States' fiscs, because many persons will be compelled to enroll in Medicaid at a substantial cost to Plaintiff States or to get coverage from intrastate exchanges that Plaintiff States must establish to avoid loss of substantial regulatory authority. As a result, the Act cannot be upheld under the Taxing and Spending Clause, Const. art. I, § 8.

74. By requiring and coercing citizens and residents of the Plaintiff States to have healthcare coverage, the Act exceeds Congress's limited powers enumerated in Article I of the Constitution, and cannot be upheld under any other provision of the Constitution.

75. By requiring and coercing citizens and residents of the Plaintiff States to have healthcare coverage, the Act deprives those citizens and residents, and NFIB members and the Individual Plaintiffs, of their rights under State law to make personal healthcare decisions without governmental interference, and violates the rights of the States as sovereigns to confer and define such rights in their constitutions or by statute, in violation of the Ninth and Tenth Amendments to the Constitution and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the individual mandate exceeds Congress's authority under Article I of the Constitution and violates the Ninth and Tenth Amendments;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, including their agencies, officials, and employees; the citizens and residents of the Plaintiff States; NFIB members and small business owners; and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT TWO

UNCONSTITUTIONAL MANDATE THAT ALL INDIVIDUALS HAVE HEALTHCARE INSURANCE COVERAGE OR PAY A PENALTY

(Const. amend. V)

76. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

77. The Act forces citizens and residents of the Plaintiff States, including NFIB members and the Individual Plaintiffs, to obtain and maintain a federally-approved level of health coverage for themselves and their dependents, regardless of whether they want or need that coverage, or pay a penalty.

78. By requiring and coercing NFIB's members and the Individual Plaintiffs to obtain and maintain such healthcare coverage, the Act deprives them of their right to be free of unwarranted and unlawful federal government compulsion in violation of the Due Process Clause of the Fifth Amendment to the Constitution of the United States.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare Defendants to have violated the rights of NFIB members and small business owners and the Individual Plaintiffs under the Due Process Clause of the Fifth Amendment;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against NFIB members and small business owners and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award NFIB and the Individual Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT THREE

VIOLATION OF CONSTITUTIONAL PROHIBITION OF UNAPPORTIONED CAPITATION OR DIRECT TAX

(Const. art. I, §§ 2, 9 & amends. IX, X)

79. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

80. Alternatively, the penalty on uninsured persons under the Act constitutes a capitation and a direct tax that is not apportioned among the States according to census data, thereby injuring the sovereign interests of Plaintiff States and the interests of all citizens and residents of the Plaintiff States and of the United States.

81. The tax applies without regard to property, profession, or any other circumstance, and is unrelated to any taxable event or activity. It is to be levied upon persons for their failure or refusal to do anything other than to exist and reside in any of the States comprising the United States.

82. The tax violates article I, sections 2 and 9 of, and the Ninth and Tenth Amendments to, the Constitution. The Act's imposition of the tax, and the resulting coercion of many persons either to enroll in an expanded Medicaid program at a substantial cost to the Plaintiff States or to get coverage from intrastate exchanges that States must establish to avoid loss of substantial regulatory authority, injures Plaintiff States' sovereign interests and violates the States' constitutional protection against unapportioned capitation taxes or direct taxation.

The tax also infringes on the right of NFIB members and the Individual Plaintiffs to be free from unconstitutional taxation. The tax is unconstitutional on its face and cannot be applied constitutionally.

WHEREFORE, Plaintiffs respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare Defendants to have violated the Plaintiff States' constitutional protection against unapportioned capitation taxes or direct taxation, and to have violate the rights of all citizens and residents of the Plaintiff States and of the United States, including NFIB members and small business owners and the Individual Plaintiffs, to be free from unconstitutional taxation;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, including their agencies, officials, and employees; the citizens and residents of the Plaintiff States; NFIB members and small business owners; and the Individual Plaintiffs, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiffs their costs and grant such other relief as the Court may deem just and proper.

COUNT FOUR

COERCION AND COMMANDEERING AS TO MEDICAID

(Const. art. I & amends. IX, X)

83. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

84. Plaintiff States cannot afford the unfunded costs of participating under the Act, but effectively have no choice other than to participate.

85. The Act exceeds Congress's powers under Article I of the Constitution, and cannot be upheld under the Commerce Clause, Const. art. I, §8; the Taxing and Spending Clause, *id.*; or any other provision of the Constitution.

86. By using Medicaid to reach universal healthcare coverage goals and forcing fundamental changes in the nature and scope of the Medicaid program upon the Plaintiff States, by denying Plaintiff States any choice with respect to new Medicaid requirements and denying them flexibility to limit the fiscal impact of those changes, by effectively co-opting Plaintiff States' control over their budgetary processes and legislative agendas through compelling them to assume costs they cannot afford, by forcing Plaintiff States to become responsible for providing healthcare services for all Medicaid enrollees, by requiring Plaintiff States to carry out insurance mandates and establish intrastate insurance programs and regulations for federal purposes, by interfering in the Plaintiff States' relationships with their employees with

respect to healthcare coverage, by commandeering the Plaintiff States and their employees as agents of the federal government's regulatory scheme at the States' own cost, and by interfering in the Plaintiff States' sovereignty, the Act violates Article IV, section 4 of the Constitution, depriving Plaintiff States of their sovereignty and their right to a republican form of government; violates the Ninth and Tenth Amendments; and violates the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress' powers under Article I of the Constitution and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

COUNT FIVE

COERCION AND COMMANDEERING AS TO HEALTHCARE INSURANCE

(Const. art. I & amends. IX, X)

87. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

88. By requiring the Plaintiff States to carry out insurance mandates and establish intrastate insurance programs for federal purposes under threat of removing or significantly curtailing their long-held regulatory authority as to intrastate insurance, and by commandeering the Plaintiff States and their employees as agents of the federal government's regulatory scheme at the States' own cost, the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress' powers under Article I of the Constitution and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

COUNT SIX

INTERFERENCE WITH THE STATES' SOVEREIGNTY AS EMPLOYERS AND PERFORMANCE OF GOVERNMENTAL FUNCTIONS

(Const. art. I & amends. IX, X)

89. Plaintiffs reallege, adopt, and incorporate by reference paragraphs 1 through 68 above as though fully set forth herein.

90. By imposing new employer healthcare insurance mandates on the Plaintiff States, by requiring that they automatically enroll and continue enrollment of employees in healthcare plans, by subjecting States to penalties and taxes depending upon plan attributes and individual employee coverage decisions, and by burdening the States' ability to procure goods and services and to carry out governmental functions, the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth

Amendments and the constitutional principles of federalism and dual sovereignty on which this Nation was founded.

WHEREFORE, Plaintiff States respectfully request that the Court:

A. Declare the Patient Protection and Affordable Care Act, as amended, to be unconstitutional;

B. Declare that the Act exceeds Congress's powers under Article I of the Constitution, and interferes in the Plaintiff States' sovereignty in violation of the Ninth and Tenth Amendments and constitutional principles of federalism and dual sovereignty;

C. Enjoin Defendants and any other agency or employee acting on behalf of the United States from enforcing the Act against the Plaintiff States, their citizens and residents, and any of their agencies or officials or employees, and to take such actions as are necessary and proper to remedy their violations deriving from any such actual or attempted enforcement; and

D. Award Plaintiff States their costs and grant such other relief as the Court may deem just and proper.

Respectfully submitted,

PAMELA JO BONDI
ATTORNEY GENERAL OF FLORIDA

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF ELIZABETH DUDEK

Pursuant to 28 U.S.C. § 1746, I, Elizabeth Dudek, declare the following:

1. My name is Elizabeth Dudek. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida Agency for Health Care Administration (AHCA) as the Interim Secretary.
2. I have served as Interim Secretary since September 2010.
3. As the Interim Secretary, I am the highest ranking official in AHCA and am responsible for

all activities of the Agency including the operation of the Medicaid program.

4. Providing this declaration is within the scope of my authority and the facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration. The facts and projections contained in this declaration regarding the impact of PPACA, however, were not originally prepared in anticipation of this or any other litigation. AHCA originally compiled the facts and projections contained herein as part of its responsibility to report to Florida's elected officials on developments that will impact the Medicaid program. AHCA has prepared and maintained those projections in the regular course of its state business.

A. Florida's Medicaid Program

5. Florida participates in the Medicaid program, and has participated continuously in the program for more than 40 years. The Federal Medicaid law requires states to designate a "single state agency" responsible for the implementation of the state's Medicaid program. 42 U.S.C. § 1396a(a)(5). [The federal law does, however, allow states under certain circumstances to bifurcate their Medicaid programs so that one agency makes eligibility determinations, while another agency serves as the "single state agency" for those found eligible. *Id.* Florida has done just that, with the Florida Department of Children and Families (DCF) conducting eligibility determinations and AHCA

administering the program for those found eligible. As Florida's eligibility agency, DCF may also be impacted by PPACA.]

6. As Florida's single state agency, AHCA cannot and does not delegate, to anyone other than its own officials, the authority to issue policies, rules, and regulations on Medicaid program matters. 42 C.F.R. § 431.10(e)(1)(ii). No other state agency or entity has the authority to change or disapprove of any of AHCA's administrative decisions, and no other state agency or entity can substitute its judgment for AHCA's with respect to the application of policies, rules, and regulations that AHCA has issued. 42 C.F.R. § 431.10(e)(3). *Id.*

7. As of fiscal year 2008-09, Florida's total Medicaid program budget (including federal and state dollars) consumed 24.16% percent of the State's total annual budget. This percentage has steadily increased over the years. In fiscal year 1991-1992, for example, the total Medicaid program budget consumed 13.10% of the total state budget.

8. For the current fiscal year, AHCA estimates that it will spend $20.2 billion dollars on the Medicaid program, which will exceed 28% of the state's total budget. AHCA anticipates that the program will serve over 2.9 million eligible recipients per month during this fiscal year.

B. Impact of PPACA

Medicaid Eligibility Expansion and Increased Rates for Primary Care Practitioners

9. PPACA requires states to cover eligibility groups not previously covered.

10. Currently, Florida Medicaid has a variety of eligibility thresholds that depend on the age and condition of the recipient. Children from birth to 1, for example, are eligible if their family income does not exceed 185% of federal poverty level. Children from 1 through 5 are eligible if their family income does not exceed 133% of federal poverty level. Children 6 through 18 are eligible if their family income does not exceed 100% of federal poverty level. Children 19 and 20, as well as adults with children who are Medicaid-eligible, are eligible if their income does not exceed 22% of federal poverty level. Aged, blind, and disabled adults are eligible if their income does not exceed 74% of federal poverty level. Aged and disabled adults who need long term care (e.g. a nursing home) are eligible if their income does not exceed 222% of federal poverty level. Pregnant women are eligible if their income does not exceed 185% of federal poverty level. Women with breast and/or cervical cancer are eligible in their income does not exceed 200% of federal poverty level. Women who have lost Medicaid coverage for any reason are provided limited family planning services for up to 24 months through the Family Planning Waiver. The program does not currently serve able-

bodied, childless adults not otherwise covered in a current categorical coverage group.

11. Starting in 2014, PPACA requires that state Medicaid programs serve all individuals under 65 with incomes of up to 133% of the federal poverty level.[1] PPACA also requires a 5% income disregard for all populations (effectively raising the eligibility threshold to 138% of the federal poverty level). These newly-mandated populations ("newly eligibles") include childless adults whom the Florida Medicaid program has not previously served. It also expands eligibility in Florida for children ages 6-20 and for parents, the aged, the blind, and the disabled who do not need long term care.

12. PPACA provides for enhanced federal financial participation for the newly eligible populations. The Federal government uses the Federal Medical Assistance Percentage (or FMAP) to determine the amount of Federal matching funds for state's expenditures for assistance payments for certain social services, including Medicaid. Through the FMAP, the federal government has traditionally funded about 55% of the Florida Medicaid program, with Florida generally funding the other 45%. With respect to the newly eligible populations, the federal government will fund 100% of the cost of serving the newly eligible population from 2014 through calendar year 2016. Thereafter, states are required to start contributing to the cost of

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[1] PPACA, § 2001(a).

serving the expansion population, with the federal government's share dropping to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond.

13. Currently, Florida has broad discretion to set reimbursement rates for health care providers who participate in the Medicaid program. Starting in state fiscal year 2012-13 (January 1, 2013), PPACA will require Florida to reimburse for certain primary care procedure codes used in the Medicaid program at a federally-mandated rate (in essence, they must be reimbursed at the same rate as in the federal Medi***care*** program). This requirement will continue through December 31, 2014. During this period the state will received 100% federal funding for the cost of the increased reimbursements. For estimation purposes, AHCA assumes that the federally-required rate increase would continue beyond the two-year period delineated in the law and these costs would then be partially funded with state funds.

14. AHCA has made projections regarding the fiscal and enrollment impact of PPACA, and presented its projections to the Florida legislature. The power point presentation created for this purpose is attached as Attachment 1 *(AHCA, Overview of Federal Affordable Care Act, August 18, 2010).* The power point presentation describes the various assumptions that went into AHCA's projections, and these assumptions can be found at pages 4 through 10 of the presentation. *See* Attachment 1. This power point presentation was not prepared in

anticipation of litigation. AHCA officials prepared it and have maintained it in the regular course of their public business.

15. The AHCA presentation projects the estimated cost to Florida of $142,460,765.00 in state general revenue in Florida's 2013-2014 fiscal year. This amount increases going forward, and by 2018-19 the projected costs to Florida are estimated to be just over a billion dollars per year, or $1,012,206,268.00, in state general revenue.

16. When fully implemented, AHCA projects that PPACA will add an additional 1.8 million people to Florida's Medicaid annual rolls, meaning that the program will, by as early as 2015, serve more than 4.5 million people annually.

17. AHCA developed projections regarding the growth in costs and enrollment as a result of PPACA which project that PPACA will result in the expansion of the Florida Medicaid caseload in four ways. First, it will extend Medicaid to persons previously ineligible (the "newly eligible"). By SFY 2018-2019, AHCA projects that this population will cost Florida roughly $351 million per year in state revenue.

18. Second, AHCA projects that PPACA will increase program enrollment of uninsured persons who are currently eligible for Medicaid but who, for whatever reason, are not currently enrolled. By SFY 2018- 2019, AHCA projects that this population will cost Florida about $574 million per year in state revenue. The estimates developed reflect a higher commitment of state

general revenue as the state will continue to receive the regular FMAP rate for this population.

19. Third, AHCA projects that PPACA will prompt some low-income individuals, who will be newly eligible for the Medicaid program under PPACA, to drop their private insurance coverage and enroll in Medicaid. By SFY 2018- 2019, AHCA projects that this population will cost Florida almost $47 million per year in state revenue.

20. Fourth, AHCA's projects reflect the transition of coverage of some CHIP enrollees to coverage under the Medicaid program. AHCA projects that children between the ages of 6-18 in families with incomes between 100-133% of FPL and currently covered by CHIP will be enrolled in Medicaid. AHCA projects that, by SFY 2018-2019, this change will cost Florida about $78 million in state revenue a year, while saving the state CHIP program about $62 million per year, for a net cost of roughly $16 million per year in state revenue.

21. Also, AHCA's projections assume that the changes PPACA makes to physician reimbursement rates will cost Florida an additional $391 million per year in state revenue by SFY 2018-2019.

22. In sum, AHCA projects that the expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Florida's costs, less so in the early years but more so after 2016.

Restrictions on State Ability to Change Eligibility and Tailor Medicaid Programs

23. Traditionally, Medicaid programs have had some authority to develop eligibility standards, including reducing eligibility for groups above mandatory coverage levels. Starting on the date of its signing (March 23, 2010), PPACA takes this type of policy-making authority away. PPACA requires all states to maintain their current eligibility standards for adults through 2014, and for children through 2019. This is known as the "maintenance of effort" requirement.

24. The maintenance of effort requirement means that Florida cannot make any change to eligibility that would render a person ineligible for Medicaid or CHIP benefits when that same person would have been eligible for benefits on March 23, 2010. If Florida fails to comply with the maintenance of effort requirement, it risks losing federal matching funds for *all* Medicaid programs, including funds that support services to pregnant women, children, and the aged and disabled populations.

25. PPACA establishes separate maintenance of effort requirements for the adult and children's Medicaid populations and, as a result, alters the state's expectations for coverage of optional categorically needy populations. The maintenance of effort requirement for the adult Medicaid population will remain in place until the U.S. Department of Health and Human Services (HHS) determines that an exchange

established by the state under PPACA section 1311 is fully operational.[2] The maintenance of effort requirement for CHIP and the children's Medicaid population up to age 19 will remain in effect through September 2019.[3]

26. As stated previously, consistent with federal law, Florida has opted to cover, as optional categorically needy groups: pregnant women between 150 and 185% of federal poverty level; women with breast and cervical cancer up to 200% of federal poverty level; and persons in need of long term care (e.g. nursing home services) between 74% and 222% of federal poverty level.

27. AHCA created these groups according to policy direction from state leadership. The maintenance of effort provision precludes the state from reducing or eliminating these previously optional eligibility groups as a matter of policy.

Loss of Prescription Drug Rebate Revenue

28. PPACA modifies the minimum Medicaid federal unit rebate amount for most drugs.[4] These modifications were made retroactively effective to January 1, 2010, and have the effect of reducing the supplemental rebates available to the states.

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[2] PPACA, § 2001(b).

[3] *Id.*

[4] PPACA, § 2501.

29. CMS provided initial guidance to states regarding PPACA's pharmacy rebate provisions on April 22, 2010. In this initial guidance letter, CMS indicated that it would retain the difference between the old and new rebate percentages across the board for all drugs, not just for those drugs for which there is an actual increase in the federal rebate amount due to the Act. Final guidance was distributed to State Medicaid Programs on September 28, 2010. In this letter, CMS revised the previous instructions concerning the Federal offset of Medicaid prescription drug rebates. At this time, the Agency is still waiting for additional information from CMS so that the Agency can invoice for federal 2010 rebates for the Fee-For-Service program as well as begin invoicing for federal rebates based on utilization from the Medicaid Managed Care Plans.

30. AHCA currently estimates that Florida will lose approximately $40 million in rebate revenue from SFY 2010-2011 for those drugs for which we are receiving rebates in excess of the current minimums.[5] During that same timeframe, the state will receive approximately $551 million in rebate revenue.[6]

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[5] These projections were developed by AHCA based on SFY 2010-2011.

[6] *Id.*

The PPACA Depends Upon State Participation in Medicaid to Achieve Its Coverage Goals

31. The PPACA provides subsidies and credits for individuals between 133% and 400% of the federal poverty level who obtain qualified coverage through a health insurance exchange, but relies solely upon state participation in Medicaid to cover individuals up to 133% of the federal poverty level.

32. In Florida, Medicaid covers and pays for health care services for almost 3 million persons, including 27% of Florida's children; pays for over 50% of Florida childbirths; pays for 63% of nursing home days; delivers services through more than 80,000 individual providers and 23 managed care plans.

33. If Florida's Medicaid and CHIP programs were ended, no current program exists that would cover the healthcare costs of individuals at 133% of the poverty level and, absent planning and implementation of some programmatic substitute, Florida would face a health care emergency affecting its poorest and neediest citizens. If Florida were to cease participation abruptly without a programmatic substitute, it would likely result in severe health repercussions, including possible loss of life, among the most desperately ill and disabled within the current Medicaid population.

34. No known federal laws or regulations provide a non-abrupt process by which a state might make an orderly wind down or transition from

Medicaid in a manner that would safeguard the health care of current Medicaid beneficiaries.

C. Attachments

35. I have attached the following document to this affidavit, which are true and correct copies of the original as maintained by AHCA:

#	Document Description
1	*Fla. AHCA, Overview of Federal Affordable Care Act, August 18, 2010*

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 3, 2010, in Tallahassee, Florida.

Elizabeth Dudek
Interim Secretary
Agency for Health Care Administration

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF JENNIFER LANGE

Pursuant to 28 U.S.C. § 1746, I, Jennifer Lange, declare the following:

1. I am making this affidavit in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.* The facts and statements in this declaration are true, correct, and within my personal knowledge.

2. I am the Director of the Automated Community Connection to Economic Self-Sufficiency (ACCESS) Program in the Florida Department of Children and Families (DCF). I am responsible for administration of eligibility

requirements and determinations for the Medicaid Program in the State of Florida. I have held this position since April 2006.

3. I am a resident of the State of Florida; I am over the age of 21; and I make the statements in this declaration based upon my personal knowledge of analysis completed by DCF, with respect to the cost of implementing an adequate eligibility system related to the Medicaid programs that complies with or meets the requirements of the Patient Protection and Affordable Care Act (PPACA), H.R. 3590.

4. The Department of Children and Families' mission statement is "Protect the vulnerable, Promote strong and economically self-sufficient families, and Advance personal and family recovery and resiliency". We pursue our mission by, among other things:

    (a) Participating in the administration of social service funds under Title XX of the Social Security Act pursuant to section 409.031, Florida Statutes;

    (b) Participating in the eligibility determination of applicants for Florida Kidcare Program pursuant to section 409.810 *et seq.*, Florida Statutes;

    (c) Administering the eligibility determination of applicants for Florida Medicaid Program pursuant to section 409.902 *et seq.*, Florida Statutes; and

    (d) Administering the eligibility determination of applicants for the

Florida Cash Assistance Program pursuant to chapter 414, Florida Statutes.

5. DCF has completed a high-level estimate of the impact of the PPACA and work that is required for the development and enhancement of DCF systems to meet the PPACA's requirements.

6. While the PPACA requires full implementation of Medicaid program changes by January 2014, technology programming must be completed sooner and require a multi-year effort beginning in 2011 to implement federal eligibility requirements in support of the PPACA.

7. To support the requirements identified in PPACA, DCF must retool the Medicaid eligibility determination component of its eligibility systems and informational web pages. PPACA also requires states to develop electronic interfaces with health subsidy programs including the American Health Benefit Exchanges.

8. DCF understands the PPACA will expand eligibility to individuals not currently covered by or eligible for Medicaid, such as individuals under age 65 with countable incomes of up to 133% of the federal poverty level, including adults who are neither disabled nor pregnant, which DCF anticipates will increase Florida's Medicaid rolls by at least 1.5 million individuals in the PPACA's early years after full implementation.

9. To accomplish the necessary programming during fiscal year (FY) 2011-12, DCF Information Systems staff project that the Department must spend $5,097,600 for FLORIDA system reprogramming ($2,528,800 in state funds and $2,528,800 in federal matching funds). Additional funding, currently estimated at $1,274,400, (half state and half federal) will be needed for FY 2012-13 to complete the programming of systems requirements not completely known at this time. The total initial estimated project cost is $6,372,000. Programming costs may change as additional requirements become defined or apparent for changes that must be in place and operational by January 1, 2014.

10. Twelve additional program office staff have been requested to start employment beginning in FY 2011, to prepare, plan, design and monitor the policy and technology needs of the expanded Medicaid system. These staff would coordinate with the Agency for Health Care Administration (AHCA) and the state health care exchanges to ensure appropriate information sharing, planning and interfaces.

11. Federal law in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, Public Law 104-193), requires states to provide medical assistance under Medicaid to individuals who meet the eligibility requirements or are included in a state plan under Title IV-A of the Social Security Act as in effect prior to passage of PRWORA. This includes children in Foster Care or Adoption

Assistance Programs under Part E and very low income families who would have qualified under the old Aid to Families with Dependent Children welfare program. Florida currently covers these individuals through Medicaid and receives federal matching funds to help cover the costs. Failure to provide Medicaid to these individuals could jeopardize Florida's TANF block grant.

12. Florida's federal TANF block grant is more than $562 million annually. These funds could be lost if Medicaid were discontinued or terminated for the above referenced individuals.

13. I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's implementation and as AHCA and the North Florida Shared Resource Center receive more guidance from the appropriate participating entities. The statements pertain to DCF ACCESS and do not include assessment of impact of costs to other entities.

Executed on November 3, 2010, in Tallahassee, Leon County, Florida.

JENNIFER LANGE
Director, ACCESS Program
Florida Dept. of Children and Families

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF J. BEN WATKINS, III

Pursuant to 28 U.S.C. § 1746, I, J. Ben Watkins, III, declare the following:

1. **I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the State of Florida (the "State") as the Director of the Florida Division of Bond Finance.**

2. **I declare that the statements made herein are based upon my personal knowledge, the Florida Statutes and State Constitution, and upon the records of the State.**

3. The State is required by its Constitution to raise "... sufficient revenue to defray the expenses of the state for each fiscal period." Article VII, Section 1(d), State Constitution. Accordingly, deficit spending is not permitted by the State.

4. The Governor is required to prepare a balanced budget of State expenditures. Section 216.162, Florida Statutes. If the Governor determines, at any time, that the recommended budget will no longer be in balance with estimated revenues, the Governor must amend the revenue or expenditure recommendations to bring the budget into balance. Section 216.168(4) Florida Statutes.

5. It is the duty of the Governor and the Chief Financial Officer to ensure that revenues being collected by the State will be sufficient to fund appropriations and that no deficit will occur in any fund of the State. Sections 216.221(1) and (8), Florida Statutes.

6. If a deficit occurs in the General Revenue Fund of the State, specific procedures are established for rectifying the budget deficit and maintaining a balanced budget, including the transfer of reserve funds to correct the deficit. Section 216.221, Florida Statutes.

7. The State's reserves have been reduced from a high of $6.1 billion at June 30, 2006, to $837 million expected at June 30, 2011.

8. State reserves have been used to mitigate spending reductions that would have otherwise been necessary to balance the State's budget.

9. The State is confronted with a projected budget deficit for fiscal 2011-12 of $2.5 billion, assuming that State General Revenue Fund reserves have been fully exhausted.

10. The State has experienced negative changes to the ratings on its debt due to difficult financial conditions. On December 11, 2008, Fitch Ratings revised its outlook for the State from stable to negative. This change was due to "... economic and revenue deterioration as well as the significant uncertainty associated with the economic and revenue outlook."

11. On January 1, 2009, Standard & Poor's Ratings Services also revised its rating outlook on the State's full faith and credit debt to negative from stable. The change was due to several factors including declining state revenues which resulted in spending reductions and a reliance on reserves to balance the State budget. The negative outlook continues to be in effect and reflects Standard & Poor's view that the State continues to confront continuing economic and financial pressure.

12. The State Constitution authorizes the State to borrow money by issuing bonds for fixed capital outlay projects only such as schools, roads and land acquisition. Articles VII and XII, State Constitution. The Constitution does not provide for borrowing for operating expenses.

13. The State's financial flexibility to absorb additional spending requirements from health care reform is severely impaired and borrowing

money to provide funding is not permitted by the State Constitution.

14. The State's credit rating and continued access to low-cost borrowing to fund investment in infrastructure may be jeopardized by budget imbalances. A downgrade of the credit rating would adversely affect the State's cost of borrowing to meet its capital needs.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed at Tallahassee, Florida, this 3rd day of November, 2010.

J. Ben Watkins, III
Director, Florida Division of Bond Finance

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF JOANNE LEZNOFF

Pursuant to 28 U.S.C. § 1746, I, JoAnne Leznoff, declare the following:

1. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the State of Florida, House of Representatives, as the Staff Director of the Appropriations Committee. As the Staff Director for the Appropriations Committee, I am the lead staff responsible for among other things, the preparation General Appropriations Act for the House of Representatives ensuring that the budget is technically correct, balanced as required by the Florida Constitution and

consistent with law. Prior to assuming this role I was a Deputy Budget Director in the House of Representatives responsible for various aspects of budget development and coordination. Prior to my tenure in the House I served in various budget related capacities in the Governor's Office of Policy and Budget and as the Director of Financial Management for the Department of Corrections. I have over 23 years of experience in state government over 10 of which have been directly related to budget.

2. I declare that the statements made herein are based upon my personal knowledge and upon the records of the State of Florida.

3. Florida's Constitution provides authority to the Florida Legislature to exercise powers reserved to the States under the United States Constitution, including the power to pass laws that make appropriations.

4. The Florida Constitution also requires that provision be made in law that raises sufficient revenue to defray the expenses of the State for each fiscal year.

5. The State of Florida's budget for Fiscal Year ("FY") 2010-11 is $70.5 billion ($43.4 billion of which is comprised of state funds). From that total budget, the State pays for infrastructure and services including but not limited to education, law enforcement, judiciary, corrections, and healthcare services.

6. The State has limited sources of funds to provide for infrastructure and services, primarily its

own source taxes and fees, and funds provided by the federal government. Additionally, Florida's Constitution allows limited borrowing for capital projects, such as school buildings, prisons, roads, and for environmentally sensitive lands.

7. Florida's Constitution also constrains the State's ability to increase revenue through increased taxation. For instance, personal income and inheritance taxes are prohibited, and other taxes are capped (intangibles tax) or require super-majority votes (corporate income tax).

8. The State of Florida has faced billions of dollars in budget shortfalls for the past several years. At the same time, the State's funding obligation to Medicaid has been substantial. Over the last decade, the State Medicaid Program has been the single largest cost driver of all government programs. At a cost of approximately $20 billion, Medicaid will serve an estimated 2.9 million Floridians in FY 2010-2011. The Medicaid program constitutes over 28 percent of the funds appropriated in the Florida State budget for FY 2010-11. The Patient Protection and Affordable Care Act of Congress ("PPACA") will significantly change the nature of Medicaid, greatly expanding both the costs and the obligations incumbent upon the State of Florida. Florida's Agency for Health Care Administration ("AHCA") estimates that these mandates may increase the State's Medicaid outlays by $1 billion or more annually by 2019.

9. Assuming the continuation of current or estimated fiscal conditions, funding the added costs imposed on its Medicaid program under the PPACA would present a significant challenge to the State of Florida. To provide that funding, the State likely would have to reduce its funding of other priorities or raise revenues. The federal portion of Medicaid funding appropriated for FY 2010-11 exceeds $12 billion and is equivalent to more than 27 percent of the total state funds in Florida's FY 2010-11 budget as well as comprising over 60 percent of the Medicaid budget. If the State of Florida were to cease participation in the Medicaid Program, the State by itself could not reasonably afford a comparable program, which would require in excess of a doubling of the outlays of state funds now devoted to Medicaid.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed at Tallahassee, Florida, this 3rd day of November, 2010.

JoAnne Leznoff
Staff Director, Appropriations Committee
House of Representatives
State of Florida

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF MICHELLE ROBLETO

Pursuant to 28 U.S.C. § 1746, I, Mary Michelle Robleto, declare the following:

1. **I am the Director of the Florida, Division of State Group Insurance (DSGI) and am responsible for employee benefit administration for the State of Florida. I have held this position since July 27, 2007.**

2. **I am a resident of the State of Florida; I am over the age of 21; and I make the statements in this declaration based upon my personal knowledge and upon the books and records of the DSGI.**

3. **I am making this affidavit in connection with** ***State of Florida, et al. v. United States***

Department of Health and Human Services, et al., a lawsuit to which the State of Florida is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge.

4. DSGI is created and governed by Florida Statutes chapter 110.123, and the regulations in Florida Administrative Code (FAC) chapter 60P.

5. DSGI administers the health, dental, vision, life, long-term disability and flexible spending account insurance programs for all eligible State officials and employees, and retirees who have chosen to participate in the DSGI insurance programs pursuant to Fla. Stat. § 110.123 (Florida State Group Insurance Program).

6. DSGI also provides assistance to participants (employees, retirees and their dependents) with questions regarding eligibility, access to services and claims, including a claim appeal process.

7. The Florida State Group Insurance Program offers a selection of comprehensive benefit programs, including both fully insured Health Maintenance Organization (HMO) options and a self-insured group Preferred Provider Organization (PPO) option. The administration and funding of the State's benefit programs is through the State Employees' Health Insurance Trust Fund, Fla. Stat. § 110.123(6).

8. About 142 thousand of Florida's state employees participate in the Florida State Group Plan administered by DSGI. About 30 thousand state employees, who work 30 or more hours a week,

do not participate in Florida State Group Plan either by choice or because Florida law excludes them from participation.

9. Federal health care reform, formally known as the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA), requires DSGI to amend the Florida State Group Plan and to offer PPACA prescribed benefits not currently offered, including:
   - extending dependent coverage to age 26 effective with the plan year beginning January 1, 2011;
   - removal of any lifetime policy limit provisions effective with the plan year beginning January 1, 2011; and
   - removal of pre-existing conditions limitations on persons to age 19, effective with the plan year beginning January 1, 2011.

10. The Division of State Group Insurance (DSGI) commissioned actuarial consulting services from Mercer Health & Benefits, LLC, under Requisition Number PR4753007-V2. The resulting work product, "Estimating the annual financial impact of federal health reform for FY 2010-11 through FY 2014-14," dated September 1, 2010 was accepted by DSGI and paid under Purchase Order A2590D.

11. Per the Mercer report, as a result of PPACA's requirements that additional benefits be given to officers and employees in the Florida State

Group Plan, increased costs will be imposed on DSGI.

12. Per the Mercer report, PPACA's requirement that DSGI expand dependent coverage to age 26 has a projected cost of $37.3 million, for the period fiscal year (FY) 2010-11 through FY 2013-14.

13. Per the Mercer report, PPACA's requirement that DSGI remove lifetime policy limits has a projected impact of $11 million for the period FY 2010-11 through FY 2013-14.

14. Per the Mercer report, PPACA's requirement that DSGI remove pre-existing conditions limitations on persons to age 19 has a projected impact of $6.2 million for the period fiscal FY 2010-11 through FY 2013-14.

15. By 2014, PPACA requires that Florida offer enrollment to all employees working 30 or more hours a week into the expanded Florida State Group Plan or pay an annual penalty based on the size of its entire workforce. Per the Mercer report, if the state decided to drop health coverage, the estimated penalty would exceed $330 million.

16. Per the Mercer report, in response to the PPACA's employer enrollment mandate and its mandate that individuals have qualifying coverage (such as through an employer plan), or pay a penalty to the federal government, DSGI expects over 20,000 additional state employees to enroll in the Florida State Group Plan at a cost of between $200 and $300 million in 2014.

17. Many of the state employees that will be newly eligible to enroll in the Florida State Group Insurance Program because of the employer mandate are designated currently as "other-personal-services" (OPS) employees (*see* Fla. Stat. § 110.123(2)(c) & (f)), who work more than 30 hours a week, but are not currently eligible for coverage in the Florida State Group Insurance Program pursuant to Florida law.

18. I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on October 21, 2010, in Tallahassee, Florida.

Michelle Robleto
Director, DSGI

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF PAT SHIER

Pursuant to 28 U.S.C. § 1746, I Pat Shier, declare the following:

I am the Director of the Division of Retirement and Benefits (Division), Department of Administration, State of Alaska. I have been in this position since 2006. I have personal knowledge of the matters set forth in the Declaration.

The Division that I direct is responsible for administering state employee pension programs. Additionally, the Division administers that active and retiree health plans collectively referred to as the AlaskaCare Health Plans. Detailed information relating to both the pension plans and the

AlaskaCare Health Plans is available on the Division's website at http://doa.alaska.gov/drb/. The Division's statutory authority to make assessments and projections relating to the active employee AlaskaCare Health Plan is derived from AS 39.30.090 - .098. As of July 1, 2009, the third party administrator for the Division is Wells Fargo Insurance Services of Alaska, Inc. (WFIS). The Division also maintains a contract with Buck Consulting Services, Inc. (Buck) for actuarial Services relating to the pension and health plans. The Division's statutory authority to retain WFIS and Buck for Services relating to the AlaskaCare Health Plan is derived from AS 39.30.090 – .098, AS 39.35.001 – .990; AS 14.25.009 – .220; and AS 22.25.010 – 090.

Providing this Declaration is within the scope of my authority, and I submit that the representations are truthful and accurate.

I confirm that both state officers and employees participate in the active employee AlaskaCare Health Plan.

Requirements and Costs for Alaska Employee Health Plan Under ACA

I confirm that the Patient Protection and Affordable Care Act (ACA) requires the Division to amend the active employee AlaskaCare Health Plan and offer certain ACA-prescribed benefits to members in the next effective plan year following September 23, 2010, as follows: (1) pursuant to ACA § 1201 (inserting § 2704 into the Public Health Service Act ("PHSA")), the Division will amend its active employee health plan to eliminate preexisting conditions for individuals under age 19 July 1, 2011; and (2) pursuant to ACA § 1001 (PHSA § 2718), by July 1, 2011, the Division will amend its active employee health plan to include coverage of dependents under age 26 who do not have coverage elsewhere.

The Division's actuarial consulting firm, Buck, estimates an increased cost due to covering dependents up to age 26 who do not have coverage elsewhere to be $275,341 in 2011. The State's actuarial consulting firm estimates no measurable costs increase following the removal of the pre-existing condition for children under age 19.

The statements and assessments stated herein are complete and accurate to the best of the Division's knowledge as of the date of this Declaration, and may be subject to revision as additional data are generated over time and as the ACA is amended or as regulations pursuant to the ACA are announced and implemented by federal agencies.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 3rd day of September, 2010.

By: ______________________________

Pat Shier, Director
Division of Retirement and Benefits
Department of Administration
State of Alaska
6th Floor State Office Building
P.O. Box 110203
Juneau, Alaska 99811-0203

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF WILLIAM L. ASHMORE

Pursuant to 28 U.S.C. § 1746, I William L. Ashmore, declare the following:

1. I am a resident of Montgomery County, Alabama, am over the age of 21 years, and I have been the Chief Executive Officer for the State of Alabama Employees Health Insurance Board since 1990. I have read the complaint filed in the above-styled lawsuit, and am familiar generally with the allegations contained therein. I have personal knowledge of the facts and matters stated within this declaration.

2. A state-wide health insurance program for employees and officers of the State of Alabama

was enacted in Alabama Acts 1965, No. 65-833, and various Acts enacted thereafter (all of which are now codified at *Ala. Code* § 36-29-1, *et seq.*).

3. *Ala. Code* § 36-29-2 established the State Employees' Health Insurance Board (hereinafter "the Board"), which is an agency of the State of Alabama. Pursuant to *Ala. Code* §§ 36-29-3 and 36-29-4, the Board was empowered and authorized to establish and administer a health insurance plan for employees and officers of the State of Alabama.

4. As a result of my long-standing service in the above capacity with the Board, I am knowledgeable concerning the development, implementation and operation of the State Employees Health Insurance Plan (hereinafter referred to as "SEHIP"). In my capacity as Chief Executive Officer of the Board one of my responsibilities is to keep abreast of health insurance trends not only for the SEHIP, but on a regional and national level as well. I continuously review and analyze claims data of the SEHIP in conjunction with national and regional trends in order to assess and project the effect on the SEHIP.

5. *Ala. Code* § 36-29-7 requires that the Chief Executive Officer of the Board certify after proper evaluation that any changes in the SEHIP are justified. Accordingly, the effect on the SEHIP of the Patient Protection and Affordable Care Act (hereinafter "ACA") are within my official duties. It is essential to the financial well-being of the SEHIP that my

projections relating to the changes mandated by the ACA be as accurate as possible.

6. *Ala. Code* § 36-29-7 and § 36-29-15 provides that state officers and employees may participate in the SEHIP. The plan currently covers 37,265 active employees and 19,280 retired employees.

7. The SEHIP meets the definition of an employer group health plan covered under the ACA. At its September 1, 2010 meeting, the Board amended the SEHIP to incorporate the following provisions of the ACA: (1) new preexisting condition requirements for individuals up through age 18 (ACA § 1201 (inserting § 2704 into the Public Health Service Act ("PHSA")); (2) exclusions for excessive waiting periods (ACA § 1201 (PHSA § 2708)); (3) lifetime and annual policy limit provisions (ACA § 1001 (PHSA § 2711)); (4) prohibition on rescission of coverage (ACA § 1001 (PHSA §2712)); (5) dependent coverage requirements (ACA § 1001 (PHSA § 2714)); (6) and reporting requirements (ACA § 1001 (PHSA § 2718)). These changes will become effective for the plan year beginning January 1, 2011.

8. As a result of the ACA's immediate requirements that additional benefits be given to employees and officers covered under the SEHIP, increased costs will be imposed on the State of Alabama.

9. Based on my experience with the SEHIP and an analysis of the additional benefits mandated by the ACA, I project that these additional benefits will increase the cost of the SEHIP by at least

$2,900,000 in 2011. This projected cost will be significantly higher in future years as additional mandated benefits are imposed by the ACA.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 7th day of September, 2010.

William L. Ashmore, Chief Executive Officer
State of Alabama Employees Insurance Board
201 South Union Street, Suite 200
Montgomery, Alabama 36104

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF KAREN BATTILANA

Pursuant to 28 U.S.C. § 1746, I, Karen Battilana declare the following:

1. **I am an adult resident of the State of Arizona and I make the statements in this declaration based upon my own personal knowledge and upon the books and records of the Arizona Department of Administration.**

2. **I am the Assistant Director of the Benefit Services Division for the Arizona Department of Administration, responsible for employee benefit administration. I have held this position since November 2009.**

3. The Benefit Services Division (BSD) administers the health, life, dental, vision, and flexible-spending insurance programs for all eligible state employees and those state retirees who choose the State of Arizona's Benefit Options Plan (the "Plan"). The BSD also assists members (employees, retirees, and dependents) with problems of access to services, eligibility, and claims.

4. The State of Arizona offers a comprehensive self-insured group medical insurance program to all State employees, retirees, and public officers. The administration and funding of State's self-insured program is through the Health Insurance Trust Fund (HITF).

5. Federal health care reform, formally known as the Patient Protection and Affordable Care Act (H.R. 3590) ("ACA"), requires the State of Arizona in 2010 to amend its Plan and offer ACA-prescribed benefits to recipients, including: (i) removal of any lifetime and annual policy limit provisions (ACA § 1001 (PHSA § 2711)); and (ii) dependent coverage requirements (ACA § 1001 (PHSA § 2714)).

6. ACA further requires the State of Arizona in 2014 to amend its Plan to include ACA reporting requirements (ACA § 1001 (PHSA § 2718)).

7. As a result of ACA's immediate requirements that additional benefits be given to officers and employees in Arizona's Plan, increased costs will be imposed on the State of Arizona.

8. ACA's immediate requirement that expands dependent coverage to age 26 has a projected increased cost of $12,050,000 for the 2011 Plan Year and a projected net increase of 3,000 new Plan participants.

9. ACA's immediate requirement that removes lifetime and annual policy limits has a projected increased cost of $ 1,217,000 for the 2011 Plan Year.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 26th day of August 2010, Phoenix, Arizona.

Karen M. Battilana,
Assistant Director
Arizona Department of Administration,
Benefit Services Division

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-3

DECLARATION OF THOMAS J. BETLACH

Pursuant to 28 U.S.C. § 1746, I, Thomas J. Betlach, declare the following:

1. I am the Director of the Arizona Health Care Cost Containment System ("AHCCCS"), Arizona's single State Medicaid agency.
2. I have worked in the AHCCCS program both as Director and Deputy Director for over eight years.
3. I have personal knowledge of the Medicaid program in Arizona and the impact of the Patient Protection and Affordable Care Act (the "Act") on the AHCCCS program.

4. The sections that follow provide further information on the Act's injurious impact on AHCCCS and, if called to testify as a witness, I could explain that impact competently.

A. Medicaid Program Prior to the Act

1. Arizona's Medicaid Program, known as the Arizona Health Care Cost Containment System ("AHCCCS"), began in 1982.

2. When the State entered into the Medicaid Program, the State understood it to be a state/federal partnership that allowed state flexibility and control over a variety of aspects of the program. This allowed states to specifically construct a Medicaid Program that is (a) tailored to meet the needs of its citizenry and (b) within its budgetary means.

3. It was Arizona's expectation that the terms of its participation in Medicaid would not be altered significantly by the federal government to expand eligibility for enrollment beyond the State's ability to fund its participation. There are certain coverage groups that have always been optional within the Medicaid Program and Arizona fully expected those groups to remain optional, at the discretion of the State, for purposes of participation within AHCCCS. The reason for this flexibility is so that the states could ensure that they were meeting the needs of the most vulnerable within their state while still living within budgetary constraints of state government.

4. Moreover, it was always Arizona's understanding that the Medicaid Program required Arizona to provide payment for medical services, as opposed to actually providing medical services as now defined under the Act.

5. Finally, Arizona entered into the Medicaid Program with the understanding that Medicaid was a partnership between the states and the federal government. The role of the federal government in the Medicaid program, as understood by Arizona at the time it began participation, was not one of coercion. Had Medicaid been an all or nothing proposition at the outset, Arizona's decision making with respect to its level of participation in the Medicaid program would clearly have been impacted both at its inception and when contemplating future expansions.

B. The Act's Injurious Impact on the Federal-State Healthcare Partnership

1. The Act eliminates Arizona's flexibility with respect to eligibility. The states used to have flexibility to carve a Medicaid program that the state felt was best suited to caring for its most vulnerable and still fell within state budgetary constraints. Defining eligibility was a key part of that flexibility that was completely eliminated by the Act. Arizona is now locked into a program that is covering over 200,000 childless adults, over 120,000 parents in an optional category and several other optional populations. Arizona has exercised the option to allow persons with an institutional level of need to participate in the

program up to 300% of the Federal Benefit Rate. AHCCCS also elected a parental income disregard for children with an institutional level of need. The State also provides coverage under the Breast and Cervical Cancer Treatment Program and Ticket to Work. These are examples of options the State has elected that now have become mandated. These are also examples of options that, during this major recession, the State simply cannot afford, but the Act has forced Arizona to retain them in the program.

2. The Act essentially requires the State to make cost-saving adjustments to the AHCCCS Program on the backs of its providers. Medicaid funding is a three-legged stool, in essence – eligibility, provider reimbursement and benefits. The Act prohibits states from adjusting eligibility. Thus, states can make changes to benefits and provider rates. Changes to benefits may save money in the short term but often are more costly in the long term because managing a member's care is more effective than paying for emergency care. Arizona has already reduced benefits by over $6 million (General Fund). Meanwhile, the real dollar savings comes from reducing rates. Provider reimbursement is critical to maintaining access to care and an adequate provider network that will meet the needs of the Medicaid members. The states cannot so damage their relationships with providers by reducing reimbursement to a point where providers are no longer willing to accept Medicaid patients. Providers should be

reimbursed fairly and adequately for the care they provide. The Act disregards this issue and forces states to reduce provider rates. Arizona has reduced payments to providers by $555,820,800 (Total Fund). In addition, recent Ninth Circuit Court of Appeals decisions regarding Section 1902(a)(30)(A), have imposed significant and costly administrative burdens on states considering provider rate reductions.

3. The Act allowed managed care organizations (MCOs) to participate in the drug rebate program for the first time. Because of the pharmaceutical industry's response, it will end up expending a lot of administrative resources for very little gain to the State. Already the process to come into compliance with the drug rebate program has required the reallocation of scarce internal resources.

4. Arizona is currently undergoing review as to whether the State will operate its own Exchange. Regardless of the outcome of that policy decision, AHCCCS will have to upgrade its eligibility systems in order to be interoperable with the Exchange such that it can screen for Medicaid/CHIP. The State will also need to acquire resources and expert staffing in order to address Exchange requirements relating to instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes. Looking to the Massachusetts example, that state needed $25 million on front end costs for Exchange and currently spends $30 million per year (funded largely through user fees).

Massachusetts' up front costs were largely funded by their State General Fund. Arizona is currently not in any position to provide that type of start up funds.

5. The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Arizona's costs, less so in the early years but more so after 2016. Arizona anticipates that the mandated expansion coupled with the woodwork effect of the individual mandate and maintenance of eligibility of previously optional groups is estimated to cost the State between $7.5 billion and $11.6 billion (General Fund) from 2011 to 2020.

6. The Act's requirement that Arizona be responsible for providing healthcare services to Medicaid enrollees (as distinguished from providing healthcare funding) will almost certainly expose the State to increased costs and litigation risks. Neither the Medicaid Act nor state law gives the State Medicaid agency any authority to compel providers to render care to Medicaid patients. The only way to encourage provider participation is to raise payment rates, which is not feasible at this time.

C. The Act's Injurious Impact on Your State

1. Based on 2008 Census Bureau statistics, Arizona has nearly 1.2 million uninsured individuals. Of those, approximately 223,000 are below 133 percent of the federal poverty line and

must be added to the AHCCCS program as required by the Act.

2. Medicaid outlays for Arizona consume roughly 20 percent of the State's budget. For FY 2009-2010, Arizona spent nearly $2 billion on Medicaid, servicing approximately 1.35 million persons.

3. It is not now feasible for Arizona to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program. The AHCCCS program accounts for approximately $9.5 billion in health care spending for the State of Arizona. Funding to hospitals alone accounts for nearly 40 percent of that spending. Moreover, AHCCCS members are integrated within the overall Arizona health care delivery system. That means that Medicaid members rely on the very same providers from whom all Arizonans receive care. Eliminating Medicaid would mean that hospital uncompensated care would skyrocket, hospitals would have to close certain departments, stop expansion projects, and physicians would see a loss in revenue. In addition, community health centers would see a severe decline in their insured patient mix. The hit to Arizona's health care system would be devastating.

4. The added costs to Arizona under the Act would not be offset by increased federal contributions under the Act. In fact, Arizona believes that overall, the Act will cost the State $7.5 billion to $11.6 billion (General Fund) from 2011 to 2020.

5. One of the most difficult aspects of the Act is allocating scarce resources in order to implement the Act's requirements. There are numerous provisions directly impacting the Medicaid program. Then there are a variety of other provisions that will require action on the part of State Medicaid programs, like the Exchange. The AHCCCS Administration is down 31% in staff, representing a reduction of over 400 employees. Meanwhile, our membership has grown by over 300,000. The AHCCCS Administration has made reductions and streamlined administrative functions wherever possible, including mandatory furlough days. Currently, all staff is focused on only critical core Medicaid functions. The Act has disrupted this focus and mandated how the State allocates scarce resources. Almost overnight, AHCCCS has had to devote funds and human resources to implement changes such as enforcing immediately-effective provisions of the Act; determining gaps between current State resources and resources that are projected to be needed to comply with the Act; evaluating current State infrastructure to determine how to implement new programs and to expand existing programs to comply with the Act; developing a strategic plan and coordinating the plan across various affected State agencies; initiating legislative and regulatory processes to comply with the Act; being familiar and dealing with federal regulatory processes to protect State interests; deciding whether to participate in optional programs under the Act; developing

communications to disseminate information regarding changes brought about by the Act to affected persons or entities in Arizona.

6. These added costs under the Act will have a significant effect on Arizona's fiscal state, lessening the General Fund's discretion to fund other critical needs such as education, corrections, law enforcement and more. To mitigate this crisis, Arizonans overwhelmingly voted to raise their own taxes by supporting a one cent sales tax increase under the leadership of the Governor. Nevertheless, the Act's mandates coupled with the end of the ARRA stimulus funding will still leave a $1 billion shortfall in the AHCCCS program.

D. Your State Cannot Avoid the Act's Requirements and Effects

1. If Arizona terminates its participation in Medicaid, 1.35 million of its most vulnerable citizens would be left without access to the healthcare services they have depended on for years under the AHCCCS program. Such an occurrence is unfathomable. Regardless, there are some within the state legislature and elsewhere who believe opting out of Medicaid is the only solution.

2. As partly noted above, ending Arizona's participation in Medicaid would devastate the overall health care system upon which all Arizonans rely. Medicaid has been critical to allowing the growth and development of Arizona's hospitals to meet the demands of a growing Arizona population since the inception

of the Medicaid program. Medicaid funding has been a significant part of hospitals' ability to gain a payor source for what was previously uncompensated care, allowing them to expand their physical capacity and develop centers of excellence that can now treat Arizonans for all their health care needs. Arizona's safety net hospitals would be completely devastated and would have to shut down beds and close down entire areas. Community Health Centers would also be hurt by the elimination of Medicaid. Since they serve as a critical safety net, having Medicaid as a payor is tremendously important. There also are so many Arizona physicians who are dedicated to caring for Arizona's most vulnerable citizens. These physicians would not be able to continue their mission without Medicaid as a payor. Of particular concern would be the impact to behavioral health providers, nursing facilities and home and community based services providers who are largely dependent on Medicaid. Finally, the impact to ancillary services, such as labs, transportation companies, etc., that support the health care community cannot be underestimated. These are important businesses in Arizona. Combined, the termination of Medicaid would not only harm health care but impact the State's economy and increase job losses.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 26th day of August 2010, Phoenix, Arizona.

Thomas J. Betlach
Director,
Arizona Health Care Cost Containment System
801 East Jefferson, MD-4100
Phoenix, Arizona 85034

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-4

DECLARATION OF PAT CASANOVA

Pursuant to 28 U.S.C. § 1746, I, Pat Casanova, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law:

1. **I am the Director of Medicaid within the Indiana Family and Social Services Administration ("FSSA").**
2. **I have been the Director since March 2009 and, prior to that, I served as a director of Agency Coordination, Integration and Policy for the Office of Medicaid Policy and Planning ("OMPP") and in various other state governmental capacities for sixteen years.**

3. The OMPP is responsible for setting policy within the FSSA for Medicaid and CHIP eligibility, rate-setting and reimbursement, and types of coverage/benefits for the citizens of Indiana. The OMPP also manages large contracts, such as those for claims processing and other business processes.

4. I have personal knowledge of the Medicaid program in Indiana.

5. Based in part on analyses competently and knowledgeably prepared by Milliman, Inc., the State's actuary, and attached as Exhibit A, I have knowledge of the impact of the Patient Protection and Affordable Care Act (the "Act") on the State's Medicaid program.

The Act's Injurious Impact on the Federal-State Healthcare Partnership

6. Indiana has always had, and has effectively utilized, the ability to control its costs by defining eligibility and benefits under its Medicaid program. The Act limits this flexibility.

7. While the Act does include 100% Federal funding to increase primary care physician reimbursement to 100% of Medicare for certain primary and preventative care services, the funding is only available for 2013 and 2014 and no Federal funding is available for other physician specialists or the full set of physician services. Thus, it appears that Indiana may be required to fund a substantial portion of the increase, estimated to be approximately $600 million for the period from January 1, 2014

through June 30, 2020, to ensure access to health care services for the current and newly eligible populations.

8. According to actuarial analysis, it is estimated that expanding Medicaid coverage to include all individuals under age 65 with incomes up to 138 percent of the federal poverty level will increase eligibility in Indiana by 413,000 parents and adults. In addition to the parents and adults, an additional 109,000 currently eligible children may enroll in Medicaid. This dramatic increase will lead to nearly 25% of Hoosiers being eligible for Medicaid.

9. By requiring that Indiana be responsible for providing healthcare services to Medicaid enrollees (as distinguished from providing healthcare funding), the Act may expose the State to increased costs and litigation risks. Neither the Medicaid Act nor State law gives the OMPP the authority to compel physicians to provide services to Medicaid patients.

The Act's Injurious Impact on Indiana

10. Based on 2008 Census Bureau statistics, Indiana has 744,600 uninsured persons living there. Of those, 274,000 are below 138 percent of the federal poverty line and must be added to the State's Medicaid rolls under the Act.

11. Medicaid outlays for Indiana consume almost 13% percent of the State's budget. For FY 2010-2011, Indiana will spend approximately $1.9 billion on Medicaid Assistance, servicing more than 1,000,000 persons.

12. It is not now feasible for Indiana to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program prior to the Act taking effect.

13. The added costs incurred by Indiana under the Act would not be offset by increased federal contributions under the Act. Indeed, the total fiscal impact to Indiana's budget during the next ten years is estimated by the State's actuary to be between $2.6 billion and $3.1 billion.

14. The Act requires that State agencies begin to immediately devote funds and human resources to implement the mandated changes, such as enforcing immediately-effective provisions of the Act; determining gaps between current State resources and resources that are projected to be needed to comply with the Act; evaluating current State infrastructure to determine how to implement new programs and to expand existing programs to comply with the Act; developing a strategic plan and coordinating the plan across various affected State agencies; initiating legislative and regulatory processes to comply with the Act; being familiar and dealing with federal regulatory processes to protect State interests; deciding whether to participate in optional programs under the Act; and developing communications to disseminate information regarding changes brought about by the Act to affected persons or entities in Indiana.

Indiana Cannot Avoid the Act's Requirements and Effects

15. No State has ever dropped out of Medicaid.

16. Indiana has no other parallel Medicaid-like program that can substitute or provide Medicaid-like benefits should Indiana's Medicaid Program be terminated.

17. If Indiana were to end its participation in Medicaid, it would likely leave many of its citizens and residents without access to the healthcare services they have depended on for years under Indiana's Medicaid Program.

Qualifying Attached Exhibits Prepared by Outside Firm

18. Indiana Code § 12-8-1-7 gives the secretary of FSSA the power to employ experts and consultants to carry out the duties of the secretary and the offices. Under this power, the Secretary of FSSA hired Milliman, Inc. to provide consulting services related to the financial review of the Act as it relates to the provisions impacting the State's Medicaid program and budget.

19. It is the OMPP's duty to make assessments and projections as the need arises and it is the agency's regular practice to do so. Milliman was asked to create Exhibit A pursuant to that practice, by persons with knowledge, and contemporaneously with the obtaining of the reported information. The OMPP provided information for the report, has reviewed it, and is satisfied that it is reliable and trustworthy. The Exhibit was not created in anticipation of litigation.

20. The assessments and projections stated herein are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision (a) as additional data are generated over time and (b) as the Act is amended or as regulations pursuant to the Act are announced and implemented by federal agencies.

21. I hereby certify to authenticity of the Exhibit.

22. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 3rd day of November, 2010.

Pat Casanova
Director of Medicaid
302 West Washington Street
Indianapolis, Indiana 46204

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-4

DECLARATION OF JERRY L. PHILLIPS

Pursuant to 28 U.S.C. § 1746, I, Jerry L. Phillips, declare the following:

1. **I am the Undersecretary of the Louisiana Department of Health and Hospitals ("DHH"), which includes Louisiana's single State Medicaid agency.**

2. **As Undersecretary, I direct the Office of Management and Finance (OM&F). The OM&F manages DHH's budget and oversees the Louisiana Medicaid program, as well as the administrative divisions with departmental responsibilities for budget preparation, financial forecasting, research and planning, purchasing,**

personnel, training, contracting, program evaluation, quality assurance, payment management, accounting, data processing, and strategic and operational planning. Additionally, I assist the Secretary and Deputy Secretary of the Department in the planning and execution of all major departmental efforts and initiatives.

3. Before becoming Undersecretary earlier this year, I worked in the Louisiana Medicaid program for ten years, first as Deputy Director and then as Director. Prior to that, I was a member of DHH's legal staff for eleven years, during which I worked closely with the Medicaid program.

4. I have personal knowledge of the Medicaid program in Louisiana and the impact of the Patient Protection and Affordable Care Act (the "Act") on Louisiana's Medicaid program.

5. The sections that follow provide further information on the Act's injurious impact on Louisiana Medicaid, and, if called to testify as a witness, I could explain that impact competently.

A. Louisiana's Medicaid Program Prior to the Act

1. Louisiana's Medicaid program began in 1966.

2. It is my understanding that when Louisiana entered into the Medicaid Program, the State understood it to be a state/federal partnership that allowed state flexibility and control over a variety of aspects of the program. This allowed states to specifically construct a Medicaid

Program that is (a) tailored to meet the needs of its citizenry and (b) within its budgetary means.

3. It is my understanding that Louisiana entered into the Medicaid Program with the expectation that the federal government's role in the program would be one of partnership with the States, not one of coercion. Louisiana fully anticipated that any expansions of Medicaid eligibility for particular coverage groups would remain optional at the discretion of the States, rather than being required by mandates from the federal government, so that the States would not be forced to expand eligibility for enrollment beyond their ability to fund their participation in the program.

4. Moreover, the Act has expanded the definition of "medical assistance" for Medicaid purposes to include, for the first time, the actual provision of health care services. Since the original definition encompassed only the payment for health care services, this represents a significant departure from Louisiana's previous understanding of what the States are required to do under the Medicaid Program.

B. The Act's Injurious Impact on the Federal-State Healthcare Partnership

1. The Act eliminates Louisiana's flexibility with respect to eligibility. The states used to have flexibility to carve a Medicaid program that the state felt was best suited to caring for its most vulnerable and still fell with state budgetary constraints. Defining eligibility was a key part of that flexibility that was completely eliminated

by the Act. Louisiana is now locked into a program that is covering over 102,000 childless adults, over 283,000 parents in an optional category and several other optional populations. Louisiana has exercised the option to allow persons with an institutional level of need to participate in the program up to 300 percent of the Federal Benefit Rate. It has also elected a parental income disregard for children with an institutional level of need. The State also provides coverage under the Breast and Cervical Cancer Treatment Program and the Medicaid Purchase Plan. These are examples of options the State has elected that now have become mandated. These are also examples of options, that during this major recession, the State simply cannot afford, but the Act has forced Louisiana to retain them in the program.

2. The Act essentially requires the State to make cost-saving adjustments to the Medicaid Program on the backs of its providers. Medicaid funding is a three-legged stool, in essence — eligibility, provider reimbursement and benefits. The Act prohibits states from adjusting eligibility. Thus, states can make changes to benefits and provider rates. Changes to benefits may save money in the short term but often are more costly in the longer term because managing a member's care is more effective than paying for emergency care. Meanwhile, the real dollar savings comes from reducing rates. Provider reimbursement is critical to maintaining access to care and an adequate provider network that will meet the needs of the

Medicaid members. The states cannot so damage their relationships with providers by reducing reimbursement to a point where providers are no longer willing to accept Medicaid patients. Providers should be reimbursed fairly and adequately for the care they provide. The Act disregards this issue and forces states to reduce provider rates.

3. The Act increases Medicaid rates for primary care physicians, and a substantial portion of that increase must be funded by the States. Louisiana estimates that this will increase its costs by approximately $186 million in State Matching Funds. In addition, the higher rates for primary care physicians may increase provider participation in the Medicaid program and broaden enrollee access to primary care services. A portion of the enrollee health care needs that are identified by primary care providers will require follow-up with specialty physician services, and increases in physician fees for those specialty services may be needed to meet related demand. This will likely cost Louisiana Medicaid an additional $38.5 million or more in State Matching Funds from 2014 to 2023.

4. Louisiana is currently undergoing review as to whether the State will operate its own Exchange. Regardless of the outcome of that policy decision, Louisiana Medicaid will have to upgrade its eligibility systems in order to be interoperable with the Exchange such that it can screen for Medicaid/CHIP. The State will also need to acquire resources and expert

staffing in order to address Exchange requirements relating to instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes.

5. The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Louisiana's costs, less so in the early years but more so after 2016. Louisiana estimates that the mandated expansion will result in the enrollment of approximately 617,000 parents and childless adults at a cost to the State of approximately $701 million in State Matching Funds from 2014 to 2023.

6. In addition, many of the individuals who are added to the Medicaid rolls as a result of this expansion will be children who are currently covered under Louisiana's Children's Health Insurance Program (LaCHIP). Because the Federal Medicaid Assistance Percentage (FMAP) rate for Medicaid is lower that the FMAP rate for LaCHIP, the federal government will pay a smaller share of the total cost of Medicaid services to children with household incomes between 101 and 133 percent of the federal poverty level, and consequently more State General Funds will be required to maintain coverage of this population. Louisiana estimates that this will cost it approximately $291 million in State Matching Funds from 2014 to 2023.

7. Louisiana anticipates that the Act's individual mandate to obtain health insurance coverage

will result in the Medicaid enrollment of more than 27,000 Louisiana parents with incomes below 11 percent of the federal poverty level who are currently eligible but unenrolled, at a cost to the State of approximately $701 million in State Matching Funds from 2014 to 2023.

8. The Act's requirement that Louisiana be responsible for providing healthcare services to Medicaid enrollees (as distinguished from providing healthcare funding) will almost certainly expose the State to increased costs and litigation risks. Neither the Medicaid Act nor state law gives the State Medicaid agency any authority to compel providers to render care to Medicaid patients. The only way to encourage provider participation is to raise payment rates, which is not feasible at this time.

C. The Act's Injurious Impact Louisiana

1. Based on U.S. Census Bureau statistics for 2008, Louisiana has more than 800,000 uninsured individuals living in the State. Of those, according to data contained in the DHH eligibility system, the U.S. Census Bureau Current Population Survey (CPS) data from 2004-2008, and the 2007 Louisiana Household Insurance Survey, there are more than 400,000 adults between the age of 19 and 64 whose income is below 133 percent of the federal poverty level, and therefore must be added to Louisiana's Medicaid rolls as required by the Act.

2. Medicaid outlays for Louisiana consume approximately 22 percent of the State's budget.

For FY 2009-2010, Louisiana spent nearly $7 billion (State Matching Funds) on Medicaid, servicing approximately 1.31 million persons.

3. It is now feasible for Louisiana to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program. The Medicaid program accounts for nearly $7 billion (State Matching Funds) in health care spending annually for the State of Louisiana. Moreover, Louisiana Medicaid members are integrated within the overall Louisiana health care delivery system. That means that Medicaid members rely on the very same providers from whom all Louisianans receive care. Eliminating Medicaid would mean that hospital uncompensated care would skyrocket, hospitals would have to close certain departments, stop expansion projects, and physicians would see a loss in revenue. In addition, community health centers would see a severe decline in their insured patient mix. The hit to Louisiana's health care system would be devastating.

4. The added costs to Louisiana under the Act would not be offset by increased federal contributions under the Act. In fact, Louisiana believes that overall, the Act will potentially cost the State approximately an additional $7 billion in State Matching funds from 2010 to 2023.

5. DHH estimates that more than 233,000 parents, children and childless adults with incomes up to 133 percent of the federal poverty level who are now covered by employer sponsored health

insurance will drop that coverage and enroll in Medicaid, at a cost to the State of approximately $1.2 billion in State Matching Funds from 2014 to 2023.

6. The health care system as a whole is financed by a mix of public and private payer sources. Public programs, such as Medicare and Medicaid, often compensate health care providers below the cost of service while private insurers compensate at or above cost. In effect, private health insurance payments underwrite the cost of uncompensated care resulting from public program payments. To offset uncompensated costs, some hospitals received Disproportionate Share (DSH) payments. Medicaid DSH payments pay for either the difference between Medicaid rates and actual cost ("Medicaid shortfall") and/or the actual cost of care to the uninsured. With the expansion of Medicaid to adults with income below 133 percent of the federal poverty level, the health care system as a whole will depend more on the Medicaid program as a payer source at the same time as DSH allocations, including those that pay for the Medicaid shortfall, to states are reduced. The result may be an increase in uncompensated cost for hospital services provided to Medicaid enrollees. Assuming that Medicaid rates for inpatient and outpatient hospital services will have to increase to 90 percent of cost to prevent or moderate increases in hospital uncompensated cost from Medicaid shortfall, Louisiana estimates that this will cost it approximately $1.8 billion in State Matching Funds.

7. One of the most difficult aspects of the Act is allocating scarce resources in order to implement the Act's requirements. There are numerous provisions directly impacting the Medicaid program. Then there are a variety of other provisions that will require action on the part of State Medicaid programs, like the Exchange. The Louisiana Medicaid Administration has made reductions and streamlined administrative functions wherever possible. Currently, all staff is focused on only critical core Medicaid functions. The Act has disrupted this focus and mandated how the State allocates scare resources. Almost overnight, Louisiana Medicaid has had to devote funds and human resources to implement changes such as enforcing immediately-effective provisions of the Act; determining gaps between current State resources and resources that are projected to be needed to comply with the Act; evaluating current State infrastructure to determine how to implement new programs and to expand existing programs to comply with the Act; developing a strategic plan and coordinating the plan across various affected State agencies; initiating legislative and regulatory processes to comply with the Act; being familiar and dealing with federal regulatory processes to protect State interests; deciding whether to participate in optional programs under the Act; developing communications to disseminate information regarding changes brought about by the Act to affected persons or entities in Louisiana. In fact,

the State has been required to add an entire new section to its Medicaid staff which is dedicated solely to ensure compliance with the Act, at an annual cost of almost $750,000 in State Fiscal year 2011 alone.

8. These added costs under the Act will have a significant effect on Louisiana's fiscal condition, decreasing its discretion to fund other critical needs such as education, corrections, law enforcement and more.

D. Louisiana Cannot Avoid the Act's Requirements and Effects

1. If Louisiana terminates its participation in Medicaid, 1.31 million of its most vulnerable citizens would be left without access to the healthcare services they have depended on for years under the Louisiana Medicaid program. Such an occurrence is unfathomable.

2. As partly noted above, ending Louisiana's participation in Medicaid would devastate the overall health care system upon which all Louisianans rely. Medicaid funding has been a significant part of Louisiana's hospitals' ability to gain a payor source for what was previously uncompensated care. Louisiana's safety net hospitals would be completely devastated and would have to shut down beds and close down entire areas. Community Health Centers would also be hurt by the elimination of Medicaid. Since they serve as a critical safety net, having Medicaid as a payor is tremendously important. There also are so many Louisiana physicians who are dedicated to caring for Louisiana's most

vulnerable citizens. These physicians would not be able to continue their mission without Medicaid as a payor. Of particular concern would be the impact to nursing facilities, intermediate care facilities for the developmentally disabled, home and community based services providers and behavioral health providers, all of whom are largely dependent on Medicaid. Finally, the impact to ancillary services, such as labs, transportation companies, etc., that support the health care community cannot be underestimated. These are important businesses in Louisiana. Combined, the termination of Medicaid would not only harm health care but impact the State's economy and increase job losses.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

Executed this 10th day of September, 2010, at Baton Rouge, Louisiana.

Jerry L. Phillips
Undersecretary, Louisiana Department of
Health and Hospitals
628 N. Fourth St.
Baton Rouge, Louisiana 70802

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-4

AFFIDAVIT OF MAGGIE ANDERSON

STATE OF NORTH DAKOTA
COUNTY OF BURLEIGH

Maggie Anderson states as follows:

1. I swear and affirm under penalty of perjury that the statements made in this affidavit are true and correct.

2. I am the Director of the Medical Services Division of the North Dakota Department of Human Services (NDDHS), which manages and oversees the North Dakota Medicaid program. My duties consist of directing the operations of the Medicaid, Children's Health Insurance, and

state-funded Home and Community-Based Services Programs.

3. The Patient Protection and Affordable Care Act restricts North Dakota's ability to define health care eligibility and attributes under North Dakota's Medicaid Program to a degree that significantly limits North Dakota's discretionary authority.

4. Based on 2008 Census Bureau statistics (Current Population Survey: Health Insurance Coverage Status by State for All People: 2008), North Dakota has approximately 74,000 uninsured persons living in the state. As of July 2010, the North Dakota Medicaid enrollment was 62,486. According to projections from the Kaiser Commission on Medicaid and the Uninsured, due to the Patient Protection and Affordable Care Act, the enrollment in the North Dakota Medicaid program could increase by 44% by 2019. *See* Ex. A at 10.

5. Medicaid outlays for North Dakota consume 12.6% of North Dakota's 2009-2011 state budget. These outlays come from the State's general fund. For State Fiscal Years 2010 and 2011, North Dakota estimates spending $408.7 million of state general funds on Medicaid. For State Fiscal Year 2009, the unduplicated count of Medicaid recipients was 77,637.

6. In my view, as Director of the state's Medicaid program, it would not be feasible for North Dakota to operate a traditional Medicaid-like program in the absence of federal funding.

7. The added costs to North Dakota under the Patient Protection and Affordable Care Act would not be offset by increased federal contributions under the Act. *See* Ex. B. Over the next 10 years it is estimated the net additional state Medicaid expenditures (state general funds) required under the Act will exceed $105 million. *See id.* at 1.

8. North Dakota, through the NDDHS Medical Services Division, the state's designated Medicaid agency, estimates some individuals who now have some form of health care insurance but fall below 133% of the federal poverty level will drop their coverage and enroll in Medicaid. Based on estimates from the US Census Bureau (Current Population Survey Annual Social and Economic Supplement (2006-2009)), there are approximately 27,679 individuals at or below 133% of the poverty level in North Dakota between the ages of 21 and 64 with insurance. If 33% of the 27,679 drop their insurance and enroll in Medicaid in 2014, it is estimated it will cost the state of North Dakota $11.1 million (based on estimated costs from the Lewin Group report, October 2009) for the period of 2014 through 2019. *See* Ex. C at 6. If 50% of the 27,679 drop their insurance and enroll in Medicaid in 2014, it is estimated it will cost the state of North Dakota $13.9 million (based on estimated costs from the Lewin Group report, October 2009) for the period of 2014 through 2019. *Id.*

9. The Patient Protection and Affordable Care Act requires that NDDHS immediately begin to

devote funds and human resources to implement changes necessary to comply with the Act.

10. Exhibit B contains assessments and projections relating to particular aspects of the Patient Protection and Affordable Care Act and the Act's impact on North Dakota's Medicaid program. Each layer of information within the exhibit has been collected, analyzed, and reported by agency personnel having knowledge, expertise, and experience for performing such tasks.

11. Exhibit B was prepared by Affiant with the assistance of Brenda Weisz, Chief Financial Officer of the NDDHS, immediately prior to the May 27, 2010 Legislative hearing at which it was presented. We regularly prepare reports on Medicaid expenditures. *See, e.g.*, NDDHS 2007-2009 Biennial Report (Nov. 2009), available at www.nd.gov/dhs/info/pubs/docs/2007-2009-dhs-biennialreport.pdf.

12. Exhibit B was not created in anticipation of litigation, but pursuant to statutory requirements or authorizations. Under N.D.C.C. § 54-06-04, NDDHS is required to prepare a biennial report that includes a detailed review of Medicaid expenditures. NDDHS regularly reviews and develops recommendations regarding various healthcare services provided to Medicaid recipients similar to the assessments and projections set forth in Exhibit B.

13. I certify that Exhibit B is an official public record. Exhibit A is a market report that contains published compilations of Medicaid

enrollment and expenditures and projections of enrollment and expenditures generally used and relied upon by the public and government officials responsible for Medicaid programs.

14. The assessments and projections stated in this Affidavit are complete and accurate to the best of Affiant's knowledge as of the date of this Affidavit, and are subject to revision (a) as additional data is generated over time, (b) as the Patient Protection and Affordable Care Act is amended or as regulations pursuant to the Act are announced and implemented by federal agencies, and (c) as NDDHS receives policy guidance from the Centers for Medicare and Medicaid Services.

15. The furnishing of the official statements in this Affidavit and in Exhibit B is within Affiant's official duty.

16. Attached as Exhibit A is a true and correct copy of Appendix F to the May 27, 2010 Minutes of the Industry Business and Labor Interim Committee, Kaiser Commission on Medicaid and the Uninsured, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL [federal poverty level], Urban Institute, May 2010, attached to NDDHS/Anderson testimony, May 27, 2010 interim committee hearing; and attached as Exhibit B is a true and correct copy of Appendix E to the May 27, 2010 Minutes of the Industry Business and Labor Interim Committee, NDDHS White House/Congressional Leadership Reconciliation

Bill Preliminary Estimate of Health Care Reform Impacts on ND Medicaid May 27, 2010, and attached as Exhibit C is a true and correct copy of the Memorandum from John Sheils and Randy Haught of The Lewin Group, to the National Governors Association on Cost and Coverage Estimates for the Medicaid Expansion Provision of the Senate Finance Health Reform Proposal in North Dakota (Oct. 5, 2009).

Dated this 11th day of October, 2010.

____

Maggie Anderson

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-4

AFFIDAVIT OF VIVIANNE M. CHAUMONT

I, Vivianne M. Chaumont, being first duly sworn, hereby depose and state as follows:

1. I am competent to testify to the matters in this Affidavit.
2. This Affidavit is based on my personal knowledge and is offered in support of Plaintiffs' Motion for Summary Judgment.
3. I am the Director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services (Nebraska DHHS). My responsibilities include the administration of the Medicaid program which is subject to requirements of state and

federal regulatory and statutory authority. Neb. Rev. Stat. § 68-904 to 956; Titles XIX, 42 USC §1396a, *et seq*.

4. The Nebraska Medicaid program is a medical assistance program, created under Title XIX of the federal Social Security Act, for individuals who fit within federally defined eligibility categories.

5. Nebraska statute requires that the State of Nebraska accept and assent to all applicable provisions of Title XIX of the federal Social Security Act. Neb. Rev. Stat. § 68-906.

6. The State of Nebraska is required to have a State Plan, which is reviewed and approved by the federal Department of Health & Human Services Centers for Medicare and Medicaid Services (CMS). The Medicaid State Plan is the "comprehensive written document, developed and amended by [Nebraska DHHS] and approved by CMS, which describes the nature and scope of the medical assistance program and provides assurances that [Nebraska DHHS] will administer the program in compliance with federal requirements." Neb. Rev. Stat. 68-907(4).

7. As Medicaid Director, I am required to ensure that the Medicaid program is administered in compliance with federal law.

8. In order to receive federal financial participation (FFP), the State of Nebraska must comply with all federal requirements of the Medicaid program. FFP accounts for nearly 60% of the

funds which pay for the Medicaid program, and amounts to over $1 billion annually.

9. As Director, I am generally aware of changes in federal law, including the Patient Protection and Affordable Care Act, PL 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, PL 111-152 (hereinafter, the Act) and it is part of my duties to consider what impact changes in federal law may have on Nebraska's Medicaid program.

10. Because the Act would add large new populations to Nebraska's Medicaid program, Nebraska DHHS retained the services of Milliman, Inc., an actuarial firm, to review the Act and submit a written analysis of the impact of that Act as it pertains to DHHS and the State's Medicaid program.

11. Milliman conducted its review and analysis and provided a report to Nebraska DHHS, a true and correct copy of which is attached and marked as Exhibit A.

12. Nebraska passed legislation to implement the Medicaid program in 1965.

13. The original Nebraska Medicaid program was established under the premise that Nebraska would be required to cover specified limited populations, including needy children and their caretaker relatives, needy disabled and needy elderly.

14. Prior to the Act, expansion of eligibles has been at the discretion of the State of Nebraska, taking into account state resources. The Act, which

would greatly expand eligibility beyond that originally contemplated by the Medicaid statute, regardless of the availability of state resources, was not contemplated.

15. The State of Nebraska has had the flexibility to stop coverage of any category of eligibles that was not mandatory. The Act takes that flexibility away from Nebraska. Not only is the federal government adding large new populations, it is restricting the state's ability to manage its resources by not allowing Nebraska to drop optional coverage of eligibles.

16. In addition, the State of Nebraska's discretion to change eligibility criteria has been taken away, as well as the State's ability to increase or implement new premiums and other tools needed to manage resources.

17. The Act increases rebate percentages for covered outpatient drugs provided to Medicaid clients. However, the Act provides that the impact of these increased rebate percentages will accrue to the federal government. The Milliman report estimates that this could reduce Nebraska's drug rebates between 20.7% to 22.6% beginning in January 2010, for a total negative impact of between $68.1 and $74.4 million dollars from state fiscal years 2011 through 2020. Please see Exhibit A.

18. The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 138% (based on the 5% disregard in the statute) of the federal poverty level will increase the State of Nebraska's share of expenses relating to

Medicaid, with the costs increasing on an accelerated basis after 2016.

19. Prior to the Act, the statute and case law have been clear that states have to pay for services, but are not responsible for providing services. The Act's requirement that Nebraska be responsible for providing health care services to Medicaid enrollees is an expansion of Nebraska's responsibility, which could easily add to litigation against the State by leading to increased costs and litigation risks.

20. Based on 2008 census bureau statistics, the State of Nebraska has 210,674 uninsured persons living in the state. Of those, 85,031 are below 138% of the federal poverty level and must be added to the State of Nebraska's Medicaid rolls under the Act.

21. Medicaid outlays for the State of Nebraska consume 19% of the state's budget. For fiscal year 2009-2010, Nebraska spent approximately $1.5 billion dollars in total funds on Medicaid, servicing approximately 201,000 persons.

22. It would not be feasible for the State of Nebraska to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid -like program prior to the Act taking effect.

23. The added cost to the State of Nebraska under the Act will not be offset by increased federal contributions under the Act.

24. The State of Nebraska estimated that 50 to 100% of persons who now have some form of

health care insurance but fall below 138% of the federal poverty level will drop their coverage and enroll in Medicaid. These persons represent a significant cost to the State of Nebraska.

25. In order to implement the Act in 2014, there are numerous administrative changes, including system changes, which need to take place prior to 2014. No additional administrative funding has been provided to the states at a time when state resources, including the State of Nebraska's resources, are shrinking. The Milliman report estimates administrative costs at $82.4 to $106.8 million dollars for state fiscal years 2011 through 2020. Please see Exhibit A.

26. The State of Nebraska established the Medicaid program by adopting a statute authorizing establishment of the program. State legislation would be required to cease the program.

Further affiant sayeth not.

Vivianne M. Chaumont
Director, Division of Medicaid
and Long-Term Care
Department of Health and
Human Services

Subscribed and sworn to before me this 14th day of September, 2010.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF JAMES R. WELLS

Pursuant to 28 U.S.C. § 1746, I James R. Wells, declare the following:

1. **I am a resident of the State of Nevada and I make the statements in this declaration based upon my personal knowledge and upon the books and records of the Nevada Public Employees' Benefits Program (PEBP).**
2. **I am the Executive Officer of PEBP and I am responsible for employee benefit administration for the State of Nevada. I have held this position since June 2010.**
3. **PEBP is created and governed by Nevada Revised Statutes (NRS) chapter 287 and the**

adopted regulations in Nevada Administrative Code (NAC) chapter 287.

4. PEBP administers the health, dental, vision, life, long-term disability and flexible spending account insurance programs for all eligible State employees, the employees of local government entities who have chosen to participate in the PEBP insurance programs pursuant to NRS 287.025, State retirees who have chosen to participate in one of the benefit plans offered by PEBP, local government retirees whose employers have contracted with PEBP pursuant to NRS 287.025 who have chosen to participate in one of the benefit plans offered by PEBP and local government retirees whose employers have not contracted with PEBP pursuant to NRS 287.025 but who were enrolled in the program on November 30, 2008. PEBP also provides assistance to participants (employees, retirees and their dependents) with questions regarding eligibility, access to services and claims, including a claim appeal process.

5. PEBP operates on a July 1 to June 30 plan year.

6. PEBP offers a selection of comprehensive benefit programs to all State employees, retirees and public officers as well as to the employees, retirees and public officers of local government organizations who contract with PEBP for health care pursuant to NRS 287.025. PEBP offers both fully insured Health Maintenance Organization (HMO) options and a self-insured group medical insurance option. The dental benefit is self-insured for all participants. The

administration and funding of the State's benefit programs is through the Fund for the Public Employees' Benefit Program (NRS 287.0435).

7. Federal health care reform, formally known as the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA), requires PEBP to amend its Plan and offer PPACA prescribed benefits to participants, including:
    a. removal of any lifetime and annual policy limit provisions (ACA § 1001 (PHSA § 2711)) effective with the plan year beginning July 1, 2011;
    b. extending dependent coverage to age 26 (ACA § 1001 (PHSA § 2714)) effective with the plan year beginning July 1, 2011; and
    c. reporting requirements (ACA § 1001 (PHSA § 2718)) effective with the plan year beginning July 1, 2011.
8. As a result of PPACA's requirements that additional benefits be given to officers and employees in PEBP's Plan, increased costs will be imposed on PEBP.
9. PPACA's requirement that PEBP expand dependent coverage to age 26 has a projected impact between $4,000,000 and $6,100,000 for the plan year July 1, 2011 to June 30, 2012 and a projected impact between $4,250,000 and $6,440,000 for the plan year July 1, 2012 to June 30, 2013.
10. PPACA's requirement that PEBP remove lifetime and annual policy limits has a projected

impact between $1,250,000 and $2,000,000 for the plan year July 1, 2011 to June 30, 2012 and a projected impact between $1,290,000 and $2,140,000 for the plan year July 1, 2012 to June 30, 2013.

11. The projections stated herein are complete and accurate to the best of PEBP's knowledge as of the date of this Declaration, and are subject to revision (a) as additional data are generated over time and (b) as the PPACA is amended or as regulations pursuant to the PPACA are announced and implemented by federal agencies.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 3rd day of September, 2010.

James R. Wells, Executive Officer
Public Employees Benefits Program

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF MICHAEL J. WILLDEN

Pursuant to 28 U.S.C. § 1746, I, Michael J. Willden, declare the following:

1. **I am the Director of the Nevada Department of Health and Human Services (DHHS). DHHS is the "umbrella organization" for Nevada's health care programs, including Medicaid and the Nevada Check-Up (CHIP) program.**

2. **I have been the Director of DHHS for over nine years and worked within the Department for over thirty-five years in many roles.**

3. **I have personal knowledge of the Medicaid and Check-up programs in Nevada and the impact of**

the Patient Protection and Affordable Care Act (PPACA) on these programs.

4. The sections that follow provide information on the Act's impact on DHHS in Nevada, most noticeably the Medicaid program, and if called to testify as a witness, I could explain that impact.

Medicaid Program Prior to the Act

1. The Nevada Medicaid program started in 1967.
2. Throughout the history of Nevada Medicaid, there has been an understanding that the federal/state partnership allowed for flexibility and state discretionary control in designing and administering the program. Restrictions of state discretionary authority have occurred in the past. However, the Act did significantly limit State discretionary authority more so than in the past by imposing Maintenance of Eligibility requirements limiting the State's ability to manage its Medicaid and CHIP programs within severe revenue and budget constraints.
3. Nevada's Medicaid program has experienced numerous federally mandated eligibility expansions from the outset. The program initially started funding medical care for the poor receiving welfare payments, primarily single parents with dependent children and aged, blind and disabled individuals. Federal legislation in the 1980 and 1990s expanded Medicaid eligibility beyond traditional welfare populations. However, the Act is expanding Medicaid eligibility requirements to

unprecedented levels. While much of this expansion will initially be fully federally funded through 2016 for those made newly eligible through the Act, it is the State's belief that many more enrollees will obtain Medicaid coverage under current eligibility standards, imposing a significant cost burden on the State. Additionally, the new administrative expense associated with this expansion is significant. The State estimates that between 2013 and 2019 the Act will incrementally cost the State more than $574 million in state general funds. (See attached "Health Care Reform projected cost.")

4. Nevada has always understood the Medicaid program to be a "vendor payment" program; reimbursing health care professionals and entities for services provided to eligible recipients. The provision of the Act to "provide medical services" is a serious concern; as yet it is unclear what the impact of this may be.

5. Nevada has historically maintained stringent eligibility requirements for its Medicaid program, however, limiting access to the program only to those most in need. The significant expansion of eligibility under the Act departs from the historical use of Medicaid in Nevada.

The Act's Injurious Impact on the Federal-State Healthcare Partnership

1. The Act restricts Nevada's ability to revise Medicaid eligibility in order to administer the program under state budgetary constraints. The

Maintenance of Eligibility requirements of the Act takes away one of the most effective cost-savings techniques available to manage the Medicaid program.

2. The Act limits Nevada's ability to operate the Medicaid program within budget constraints through Maintenance of Eligibility provisions. This instead requires the State to reduce provider payments, and reduce or eliminate essential services. Reductions in provider rates not only affect access to care for recipients, but also lead to cost-shifting to other payers and patients by provider. These changes are necessary for Nevada to continue to operate its Medicaid program, but may have the long-term effect of increasing costs due to delays in access to services that result in avoidable hospital admissions and emergency room services.

3. The Act requires the State to pay primary care physicians the Medicare rates in effect 2013 and 2014. There will be 100% federal financing during this time based on Medicare rates in effect in 2009. The State will need to decide whether it will continue paying physicians at that level or to lower the rates after 2014. Assuming the State continues to pay primary care physicians at the Medicare level, the estimated cost between 2013 and 2019 is approximately $28.8 million in state general funds.

4. The Act changes how Medicaid drug rebates are calculated and shared with the federal government. The Act increases the minimum

federal drug rebates for fee for service Medicaid program increase from 15.1 to 23.1 percent of the average manufacturer price. Nevada estimates that the increase in the minimum drug rebate percentage will save approximately $881,000 in state fiscal year 2012. However, this increase may be partially offset by the need to increase payments to managed care plans for their loss of discounts and rebates also associated with the Act.

5. The Act expands Medicaid eligibility for individuals under age 65 with incomes up to 138 percent of the federal poverty level. Nevada estimates that between 2013 and 2019 the Act will incrementally cost the State more than $574 million in state general funds. (See attached "Health Care Reform projected cost.")

6. The Acts requirement that Nevada be responsible for providing healthcare services to Medicaid enrollees, as distinguished from paying providers for health care services, is a serious concern. However, until the full scope of the language of the Act cannot be assessed until regulations are promulgated by the Centers for Medicare and Medicaid Services (CMS).

The Act's Injurious Impact on Your State

1. Based on the 2008 Census Bureau statistics, Nevada had 486,000 uninsured people living here. Of those, an estimated 155,500 are below 133 percent of the federal poverty line and must be added to Nevada's Medicaid rolls under the act.

2. Medicaid outlays for Nevada consume more than 15% of the state budget. For the fiscal year that ended June 30, 2010, Nevada was budgeted to spend nearly $385 million in state general funds on Medicaid programs, servicing approximately 221,235 people.

3. Nevada estimates that by 2019, more than 56,000 currently eligible non-recipients of Medicaid will enroll in the program because of the Act's requirement for individuals to have insurance coverage. The estimated cost to provide medical benefits to this group between 2014 and 2019 is $348 million in state general funds. This estimate is based on the understanding that federal financial participation for this group of eligible recipients will be at the regular Federal Medical Assistance Percentage (FMAP), which for purposes of this calculation was assumed to be 50.00%. (See attached "Health Care Reform projected cost.")

4. Current estimates are that between 2013 and 2019, the State will need an additional $574 million in state general funds to cover the cost of the Act's Medicaid expansion. Although that estimate includes about $35 million for a replacement of the state's current eligibility system to handle increased caseload due to reform. However, this estimate does not include potential costs associated with building a health insurance exchange, or other related information technology costs. (See attached "Health Care Reform projected cost.")

5. Nevada has evaluated the potential effects of opting out of the Medicaid program entirely. The issues and impacts are included in a white paper (attached) entitled "Medicaid Opt Out." Nevada feels that the affects of ending its Medicaid program would be extremely harmful to recipients and providers, and would have wide-ranging affects on state and local government entities, schools, hospitals and safety net programs. It is estimated that almost 200,000 Nevada residents would lose medical coverage. Nor would they be eligible for subsidizes health insurance exchange coverage provided in the Act. Critical long term care services for the elderly, disabled, as well as services for individuals with mental retardation and developmental disabilities would no longer be funded. Nursing facilities, with a high percentage of Medicaid patients making up their census, would be at risk of closure due to the loss of Medicaid revenue. Access to essential acute medical services, like physician and hospital services, would no longer be funded for these individuals, putting those with chronic medical conditions at serious risk. Community based supports and services that keep people out of institutions would not be available and likely would not be paid for through health insurance exchange plans, leading to unnecessary placements in nursing facilities and group homes. Eliminating Nevada Medicaid would also impact state and local government agency funding by eliminating federal Medicaid dollars as a source of revenue. This would affect adult

and children's mental health services, as well as services provided by county agencies and schools. Local government agencies would also see a significant reduction in federal revenues which would challenge their missions to serve the general public. Finally, supplemental payments to safety net hospitals would cease putting programs and services that provide essential community benefits at risk, such as HIV and AIDS clinics and clinics for high risk pregnant women. After considering these impacts, Nevada has determined that is cannot opt out of this essential program.

6. The added costs to Nevada associated with the Act will have a significant effect on the State's fiscal condition, beyond those it is currently experiencing. As demonstrated above, the incremental costs to Nevada associated with implementation of the Medicaid provisions of the Act are not offset by the federal funding support included the Act.

7. The Act's provisions also provide an opportunity for small businesses to consider dropping their current employer based insurance and allowing their employees to elect coverage through the health insurance exchange. Many of these employees are low-wage workers and will likely be eligible for expanded Medicaid coverage below 138% of the federal poverty level. We estimate that as many as 40,000 individuals previously covered through their employer may instead get their coverage through Nevada Medicaid.

8. To fund these incremental costs associated with the Medicaid provisions of the Act, Nevada will inevitably need to reduce spending in other essential areas that the State is already struggling to fund, including K-12 education, prisons, law enforcement and its universities and community colleges.

9. The Act includes timeframes that require Nevada begin spending funds to plan and implement a number of changes to the Medicaid program this fiscal year. The State has hired two dedicated staff to work solely on managing the Medicaid and Children's Health Insurance Program (CHIP) provisions of the Act. We have already engaged a consulting firm to help us with planning for numerous aspects of the Act. The largest component of these plans includes the development of a new electronic eligibility system that will be essential for determining Medicaid and CHIP eligibility. Legislative Interim Finance Committee contingency funding totaling $279,118 was requested and provided to support the initial planning effects. Also to date Nevada has tracked 6522 planning hours by staff at a cost of $257,101. (Cost summary and memo attached.)

10. Nevada DHHS engaged the consulting firm Public Consulting Group (PCG) to assist us in planning to implement a Health Insurance Exchange and to develop a new electronic eligibility system to interface Medicaid/CHIP with an exchange. PCGs estimated costs for the "eligibility engine" was $23,849,037. Ongoing

annual costs are estimated at $3,765,163. (PCG Study attached.)

Your State Cannot Avoid the Act's Requirements and Effects

1. The Act provides subsidies and credits for individuals between 100% and 400% of the federal poverty who obtain qualified coverage through the health insurance exchange. However, individuals below 100% of the federal poverty level are not eligible for subsidized coverage. Hence, should Nevada be forced to consider opting out of Medicaid, these individuals may find that health coverage is unaffordable and hence unavailable.
2. It is our current belief that the Act does not revise provisions of the Social Security Act that deal provide the option for the State to participate in the Medicaid program. As such, Nevada can still consider opting out of Medicaid a viable option. However, given the concerns outlined in the white paper, "Medicaid Opt Out," it is unlikely the State will chose to end its Medicaid program.

I declare under penalty of perjury that the foregoing is true and correct based on the information available to the Division.

Dated this 3rd day of September.

MICHAEL J. WILLDEN
DIRECTOR, DEPARTMENT OF
HEALTH AND HUMAN SERVICES

AFFIDAVIT OF STEVEN R. VAN CAMP

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

PERSONALLY APPEARED before me, Stephen R. Van Camp, who being duly sworn, attests to the following:

1. He is the Director of the State of South Carolina's Employee Insurance Program, which administers the Group Health Benefits Plan of the Employees of the State of South Carolina, the public school districts, and participating entities (typically referenced as the "State Health Plan").
2. He is familiar with the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (ACA).
3. State Health Plan participants include state officers as well as employees of:
   - State agencies (pursuant to S.C. Code Ann. § 1-11-710)
   - Public school districts (pursuant to § 1-11-710)
   - Other participating entities/local subdivisions that elect to participate pursuant to § 1-11-720

   Participants also include retirees of these employers as defined in § 1-11-730 and the eligible spouses and eligible children of employees and retirees.

4. On January 1, 2011, the State Health Plan will comply with the following ACA-prescribed benefits that were not previously provided under the Plan:

   - No preexisting condition exclusion for individuals younger than 19
   - No lifetime limits on essential benefits
   - Restricted annual limits on essential benefits
   - Prohibition on rescission of coverage
   - Dependent coverage of children younger than 26 (Prior to 2014, the State Health Plan will require that the child is not eligible for other employer-sponsored group health plan.)

5. The ACA's immediate requirement that additional benefits be given to officers and employees under the State Health Plan will require an increase in budgeted contributions from the State of $19.34 million for plan year 2011 (January 1 to December 31).

6. The State Health Plan has "grandfather status" at least through 2011. If this status is lost due to the State's failure to adhere to requirements of the ACA, such as not increasing the co-insurance or co-payment costs, then the State would incur substantial additional costs under the ACA of $60-70 million a year. If the State adheres to the ACA's prohibition on making changes in the State Health Plan, then the State could incur substantial additional costs of

funding the existing plan. These costs cannot be estimated at this time.

7. If the State were penalized in the future for not offering coverage to all full-time employees, the penalty would at least be $2,000 times the total number of employees of State agencies and public school districts. State agency and public school district employment now is approximately 120,000. Therefore, any such penalty could be as much as $240,000,000. Should the penalty be applied to local subdivisions and other entities that elect to participate pursuant to § 1-11-720, the penalty amount would greatly exceed this sum.

8. Should the State continue to offer the State Health Plan for employees of State agencies and public school districts in the future, and one or more of said employees chooses to enroll in a federally subsidized plan from an exchange instead of the State Health Plan, the penalty to the State would be $3,000 for each such employee enrolled in an exchange. Such penalty would not exceed $240,000,000. The number of employees who might enroll in such an exchange is speculative at this time.

9. The intention of this affidavit is to estimate costs and possible penalties that could be incurred by the State in the future under the ACA. The costs and possible penalties are projections now because regulations are still being developed. The State does not waive any claims or defenses that it might have now or in the future as to any penalty or attempted

application of ACA provisions to the State or its Health Plan including, but not limited to, the above matters.

SWORN TO before me this 28th day of September, 2010

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF DEBORAH K. BOWMAN

Pursuant to 28 U.S.C. § 1746, I, Deborah K. Bowman, declare the following:

1. I am the Secretary of the South Dakota Department of Social Services and have acted in that capacity since my initial appointment on April 5, 2005. As Secretary, I am charged with overseeing the activities of the South Dakota Department of Socials Services (DSS).

2. This Declaration is based upon personal knowledge, information received from my staff based upon their personal knowledge and records maintained by DSS.

3. DSS's statutory duties and responsibilities are many. One duty is to administer South Dakota's Medicaid Program. DSS has been designated by the Governor as the state Medicaid agency for South Dakota.

4. South Dakota began participating in the Medicaid Program in 1967. Neither I nor my staff have personal knowledge, and DSS maintains no records, regarding South Dakota's expectations at the outset of its participation in the Medicaid Program.

5. Over the years, South Dakota's Medicaid Program has grown, as well as the cost to operate the program. In 1987, there were roughly 36,000 individuals enrolled in the Medicaid Program. Today, on a monthly average, there are roughly 101,000 enrolled individuals. These numbers do not include those individuals covered by the Children's Health Insurance Program (CHIP).

6. South Dakota's financial responsibility percentages for Medicaid Program benefit expenditures for recent federal fiscal years are:

FFY 02 - 34.07%
FFY 03 - 34.71%
FFY 04 - 34.33%
FFY 05 - 33.97%
FFY 06 - 34.93%
FFY 07 - 37.08%
FFY 08 - 39.97%
FFY 09 - 37.45%
FFY 10 - 37.28%
FFY 11 - 38.75%

For federal fiscal year 2010, this percentage was reduced to 29.20%, due to South Dakota's receipt of federal stimulus outlays under the American Recovery and Reinvestment Act (ARRA). The cost share percentage will rise in federal fiscal year 2011 to 31.08%. It is anticipated for fiscal year 2012, except for payment increases specified under the Patient Protection Affordable Care Act (PPACA), that South Dakota's cost share percentage will be 40.87%.

7. Despite South Dakota's relatively low cost share percentage, state funded Medicaid Program expenditures constitute the second largest expenditure of state general funds following education. South Dakota's share of Medicaid Program costs for fiscal year 2011 constitutes 22.93% of the general fund budget ($266,308,429.00 of the total general fund budget of $1,160,406,651.00). It is anticipated that during fiscal year 2011, over 141,000 persons will be served under South Dakota's Medicaid Program.

8. I have been asked to estimate the immediate fiscal impact that the PPACA will have on South Dakota's Medicaid Program. The estimates set forth below are complete and accurate to the best of my current knowledge and information as of the date of this Declaration.

9. The PPACA has required DSS to immediately devote substantial funds, resources and personnel to implement the required Medicaid Program changes. Implementation of PPACA will tax DSS resources and will require

additional state expenditures for associated costs. It is not possible to estimate the amount DSS will spend annually for state fiscal years 2011 through 2014 in money, resources and staff time to implement and comply with PPACA provisions. Lack of guidance from the federal government on the effect PPACA will have on the South Dakota Medicaid Program is a major factor in the ability to estimate.

10. The PPACA will have a significant long term impact on South Dakota's Medicaid Program. The number of individuals eligible for Medicaid will significantly increase. South Dakota will be required to expend additional state funds to provide Medicaid benefits to these individuals and pay increased administrative costs to comply with PPACA required changes.

11. The PPACA also reduces South Dakota's flexibility to manage the ever increasing costs of its Medicaid Program. The Act's provisions significantly restrict South Dakota's ability to reduce services, reimbursement rates and eligibility qualifications.

12. PPACA § 2301 changes the definition of medical assistance and requires South Dakota to provide medical services, as distinguished from providing payment for medical services. The prior definition was the basis for Medicaid Program payments prior to the PPACA. This definitional change may significantly alter South Dakota's Medicaid Program. To date, the Department of Health and Human Services has provided no guidance on whether or how the

definitional change of medical assistance affects South Dakota's Medicaid Program. In operating its Medicaid Program, South Dakota has relied heavily on the prior definition to provide the same payments for the same service regardless of provider or locality. This may not be the case under the new definition and a wave of litigation to determine the affect of this new definition is likely. In addition to litigation costs, the outcome of this litigation may significantly effect South Dakota's administration of this Medicaid Program as well as dramatically increasing program costs.

13. It is estimated that as a result of PPACA South Dakota's Medicaid average monthly enrollment will increase from approximately 101,000 to 155,100 individuals. Based upon 2008 Census Bureau Statistics, South Dakota has 98,000 uninsured residents. Of those, it is estimated that 48,000 are below 133% of the federal poverty line. With the 5% income disregard mandated by federal requirements, DSS estimates that an additional 49,600 individuals will be added to the South Dakota's Medicaid Program. It is also estimated that an additional 4,500 persons, who currently are eligible for Medicaid but have not enrolled, will enroll and obtain benefits, a result of the various PPACA insurance provisions going into effect, such as the PPACA's individual mandate. As to this latter category of individuals, South Dakota will have to pay its traditional Medicaid cost share, as the PPACA does not contemplate additional federal funds covering these expenditures.

14. DSS estimates that the increased costs to South Dakota associated with the projected Medicaid Program enrollment increases will be $62,600,000 from 2010 through 2019 and $36,000,000 annually thereafter. This estimate does not take into account any inflationary increases, increased provider payments and additional administrative costs.

15. Implementation of the PPACA's Medicaid Program provisions will increase state expenditures necessary to cover DSS's administrative costs. PPACA does not alter the current requirement that South Dakota must cover 50% of all Medicaid Program administrative expenses. It is estimated that South Dakota will expend an additional $37.1 million to cover PPACA related administrative expenses for 2014 through 2019.

16. Though theoretically possible, South Dakota cannot cease participation in the Medicaid Program. Currently, South Dakota is required to continue participation as a condition it agreed to when it accepted ARRA funds for Medicaid related costs. This agreement allowed South Dakota to free up state funds needed for other state expenditures due to revenue short falls arising during the latest recession. Even without the receipt of ARRA funds, it is not economically feasible for South Dakota to terminate its Medicaid Program and separately provide comparable benefits to South Dakota citizens. South Dakota's Medicaid budget (state and federal funds) for state fiscal year 2011 is $877,749,102.00. To provide pre PPACA

Medicaid benefits, South Dakota would be required to expend 75.58% of its total state general fund budget. There simply would not be enough money remaining to fund other vital state programs such as education. Further, to terminate the Medicaid Program and not provide comparable benefit coverage, would be very detrimental to the 101,000 persons who monthly receive healthcare paid by the South Dakota Medicaid Program. For example, Medicaid pays for 60% of the individuals living in South Dakota nursing homes.

17. Termination of South Dakota's participation in Medicaid would also have a severe impact on the state's healthcare providers. For example, approximately 60% of nursing home revenue is through Medicaid. Medicaid constitutes between 10 and 12% of general hospital revenues in any given year. This amount increases to approximately 25.2% for rural health care clinics and federally qualified clinics.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 21st day of September, 2010.

Deborah K. Bowman
Secretary, Department of Social Services
Kneip Building
700 Governors Drive
Pierre, SD 57501

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF SANDRA J. ZINTER

Pursuant to 28 U.S.C. § 1746, I, Sandra J. Zinter, declare the following:

1. I am the Commissioner of the South Dakota Bureau of Personnel and have acted in that capacity since my initial appointment on June 6, 1995. As commissioner, I am charged with overseeing the activities of the South Dakota Bureau of Personnel (BOP).

2. This Declaration is based upon personal knowledge, information received from my staff based upon their personal knowledge, and records maintained by BOP.

3. BOP is the state agency authorized under South Dakota Codified laws chapter 3-12A to establish and administer health, life and flexible-spending benefit insurance plans for eligible state employees, former employees who wish to continue coverage under COBRA, retired employees and their dependents (State Plan). The State Plan is self-insured. The State Plan is funded by appropriations from the South Dakota Legislature and various member payments. For state fiscal year 2011, the Legislature has appropriated approximately $78,000,000 for the State Plan.

[* * *]

cost for coverage under the State Plan could be much higher if dependents are included and COBRA is applicable.

10. ACA § 6301, effective 2012, requires South Dakota to pay the federal government a $1 comparative effectiveness excise tax for each member of the State Plan. This excise tax is $2 per member for 2013 and the tax is payable annually through 2018 with inflationary increases. The estimated cost of the seven year excise tax without the inflation increases is $460,000.

11. It is estimated that the lifetime annual policy limit provisions (ACA § 1001, PHSA § 2711) will cost South Dakota an additional $1,000,000 for state fiscal year 2012 which will escalate thereafter due to increased healthcare costs and an aging state work force. It is estimated that the required preventative care requirements

(ACA § PHSA 2713) will cost South Dakota an additional $2,000,000 annually. It is estimated that the immediate impact of the preexisting condition requirements for individuals up through age 18 (ACA § 1201, PHSA § 2704); dependent coverage requirements (ACA § 1001, PHSA § 2714); and reporting requirements (ACA § 1001, PHSA § 2718) will cost South Dakota an additional $150,000 annually.

12. Additionally, there will be other ACA compliance related cost increases to the State Plan which BOP is unable to estimate at this time. BOP is unable to provide cost estimates regarding ACA §§ 1511 and 1513 that create potential liability by penalizing South Dakota due to state employees choosing to enroll in a federal-subsidized plan from an exchange instead of the State Plan. Also, BOP is unable to determine whether the benefits provided under the State Plan will subject South Dakota to potential liability for providing "high cost" benefits that exceed a federally defined threshold (ACA § 9001).

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 29th day of September, 2010.

Sandra J. Zinter, Commissioner
Bureau of Personnel
500 E. Capitol Building
Pierre, SD 57501

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-5

DECLARATION OF BILLY R. MILLWEE

Pursuant to 28 U.S.C. § 1746, I, Billy R. Millwee, declare the following:

My name is Billy Millwee. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Texas Health and Human Services Commission (HHSC) as the Associate Commissioner for Medicaid and the Children's Health Insurance Program (CHIP), also referred to as the State Medicaid/CHIP Director.

I have served as State Medicaid/CHIP Director since January 2010. I have 15 years experience working in the Medicaid program, including serving as the deputy Medicaid/CHIP director, administering the Medicaid claims administration contract with the Texas Medicaid and Healthcare Partnership, and managing HHSC's Medicaid Eligibility and Health Information System.

As the State Medicaid/CHIP Director, I am responsible for administering the Texas Medicaid program, including serving as the primary point of contact with the federal government and implementing policy direction established by the Texas Legislature and state leadership. Based on my employment, I am familiar with the Patient Protection and Affordable Care Act (PPACA) and the effects of PPACA on the Texas Medicaid program.

I am making this affidavit in connection with State of Florida, et al. v. United States Department of Health and Human Services, et al., a lawsuit to which the State of Texas is a party.

A. The Texas Medicaid Program

Congress established the Medicaid program under Title XIX of the Social Security Act of 1965. Following authorization by the Texas Legislature, Texas began participating in the Medicaid program in September 1967.

The Texas Medicaid program consumes approximately 25% percent of the State's budget.[1] For FY 2009-2010, Texas will spend $22 billion/year on Medicaid services to approximately 4.3 million individuals.[2]

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[1] *See* General Appropriations Act, Chapter 1428, 80th Leg., R.S., 2007; General Appropriations Act, Chapter 1424, 81st Leg., R.S., 2009.

HHSC has been the single state agency for the Texas Medicaid program since January 1993. As the single state agency, HHSC's Medicaid responsibilities include:

- Administering the Medicaid State Plan;
- Contracting with the various state departments to carry out certain operations of the Medicaid program;
- Operating the state's acute care, vendor drug, and Medicaid managed care programs;
- Determining Medicaid eligibility; and
- Approving Medicaid policies, rules, reimbursement rates, and oversight of operations of the state departments contracted to operate Medicaid programs, subject to direction from the Texas Legislature and state leadership.

In Texas, HHSC delegates some day-to-day operations of the Medicaid program to other state agencies, such as the Texas Department of Aging and Disability Services, the Texas Department of Assistive and Rehabilitative Services, and the Texas Department of State Health Services.[3] Each of these operating departments will be impacted by PPACA.

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[2] *Id.*

[3] *See* Attachment 1, *Figure 3.3: Medicaid Operating Departments, 2008*, Texas Medicaid in Perspective, 7th Edition, January 2009, p. 3-10.

B. Impact of PPACA

Restrictions on State Ability to Define Eligibility and Tailor Medicaid Programs

PPACA precludes a state from adopting eligibility standards, methodologies, or procedures for Medicaid or CHIP that are more restrictive than those in place on March 23, 2010, the date PPACA was signed into law.[4] This requirement is the "maintenance of effort" requirement.

The maintenance of effort requirement means that Texas cannot make any change to eligibility that would render a person ineligible for Medicaid or CHIP benefits when that same person would have been eligible for benefits on March 23, 2010. If Texas fails to comply with the maintenance of effort requirement, it risks losing federal matching funds for *all* Medicaid programs, including funds that support services to pregnant women, children, and the aged and disabled populations.

Through the maintenance of effort requirement, PPACA severely restricts the discretion of the Texas Legislature and state leadership to design programs and allocate the state's limited resources in the way that best serves all Texans. Further, by imposing an immediate freeze effective on the date of its passage, PPACA deprives the state of any opportunity to evaluate its current allocation of resources and to make adjustments in preparation for the long-term commitments required under the Act.

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[4] PPACA, § 2001(b).

Women's Health Program

The Women's Health Program (WHP) is a five-year Medicaid demonstration project authorized by the Texas Legislature in 2005 to expand access to preventive health and family planning services for women. The statute authorizing the project, section 32.0248 of the Texas Human Resources Code, expires September 1, 2011. CMS approved the state's request for a demonstration project and HHSC implemented the WHP beginning January 1, 2007. The WHP is scheduled to expire December 31, 2011.

Although HHSC believes that the statutory and CMS-approved expiration dates are not a "more restrictive" eligibility standard, methodology, or procedure than was in effect before March 23, 2010, CMS's interpretation of the maintenance of effort requirement indicates that CMS may require Texas to maintain coverage of all clients served through the WHP until the maintenance of effort requirement expires. Thus, Texas may be required to extend the WHP even if the Legislature decides not to renew or extend the statute beyond September 1, 2011, or wishes to change the scope of program benefits or conditions of eligibility.

HHSC has asked CMS for guidance as to whether Texas may rely on CMS's prior approval and allow the project to expire by its terms without violating the maintenance of effort requirement. Further, HHSC asked CMS for guidance as to whether, if CMS believes failure to renew the statute would violate the MOE provision, Texas will need to take specific action, either through an extension or

State Plan amendment, to continue the program.[5] CMS has not yet responded.

Home and Community-Based Services Waiver Programs

Medicaid Home and Community-Based Services (HCBS) waiver programs are optional programs created by a state, with permission from CMS, under §1915(c) of the Social Security Act. Through the use of waiver programs, a state can provide a broad array of home and community-based services to targeted populations as an alternative to institutionalization. States historically have had discretion to tailor the size of HCBS waiver programs and to allocate funding to accommodate changing service needs and limits on available resources.

Under PPACA, it is not clear that the state retains the discretion to control the services or size of its waiver programs. PPACA requires the state to maintain eligibility standards, methodologies, and procedures for a waiver program and gives the state the option of rolling the waiver services into the State Plan services; it is not clear whether these instructions are meant to preclude termination or reduction in the size of a waiver program.

CMS has not issued guidance on the application of PPACA's maintenance of effort requirement to the HCBS waiver programs. However, CMS did issue guidance on the application of a similar maintenance of effort requirement in the American Recovery and Reinvestment Act (ARRA). In State Medicaid Director Letter #09-005, CMS provided a list of examples that CMS considers to be restrictions on "eligibility standards, methodologies, or procedures," that includes:

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[5] *See* Attachment 2, Letter from Billy R. Millwee to Juliana Sharp, dated July 16, 2010, concerning the Women's Health Program.

- Reducing occupied waiver capacity for section 1915(c) HCBS waivers.
- Reducing or eliminating section 1915(c) waiver slots that were funded by the legislature but unoccupied as of July 1, 2008.[6]

These restrictions could be interpreted to limit the Texas Legislature's discretion to allocate funding for waiver programs. Texas may not have the flexibility to implement small reductions in funds appropriated for some waiver programs based on budget constraints and performance goals that are intended to assure client service needs.

HHSC has asked CMS to reconsider its interpretation of ARRA's maintenance of effort requirement and to provide guidance on the application of PPACA's similar requirement to the HCBS waiver programs.[7]

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[6] State Medicaid Director Letter (SMDL) #09-005, available at http://www.cms.gov/SMDL/downloads/SMD081909.pdf (Letter) and http://www.cms.gov/SMDL/downloads/SMD081909Att2.pdf (Enclosure B), last visited September 2, 2010.

[7] *See* Attachment 3, Letter from Billy R. Millwee to Cindy Mann, dated September 1, 2010, concerning the HCBS Waiver Programs.

Treatment of Children and Adults in Optional Programs

PPACA establishes separate maintenance of effort requirements for the adult and children's Medicaid populations and, as a result, significantly alters the state's expectations for coverage of optional categorically needy populations. The maintenance of effort requirement for the adult Medicaid population will remain in place until the U.S. Department of Health and Human Services (HHS) determines that the state's health insurance exchange is fully operational.[8] The maintenance of effort requirement for CHIP and the children's Medicaid population up to age 19 will remain in effect through September 2019.[9]

Consistent with federal law, Texas has opted to cover, as optional categorically needy groups, individuals who are eligible under a special income level and who are in nursing facilities; ICF-MR facilities; acute care hospitals; and institutions for mental diseases for individuals over the age of 65. With one exception, these groups—unlike the PPACA's maintenance of effort requirements—are not age-specific.

HHSC created these groups according to policy direction from state leadership and with the understanding that, in accordance with federal statute and regulation, if the state provided Medicaid coverage to one eligible individual in a group, it would provide Medicaid coverage to all eligible individuals. If, therefore, the state provides Medicaid coverage to children in an optional categorically needy group that is not age-specific, the state also must cover adults in the same group. So, while PPACA's maintenance of effort requirement for the adult Medicaid population purportedly ends when the health insurance exchange is operational, it is in effect extended through September 2019 with respect to adults in these non-age-specific, optional categorically needy groups. As a result, Texas is forced to provide Medicaid coverage to adult and child members of an optional categorically needy group through September 2019, although it may be more cost-effective for the state if the adult group members can be covered through the Exchange.

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[8] PPACA, § 2001(b).

[9] *Id.*

Primary Care Physician Rate Increases

PPACA increases Medicaid rates for primary care services furnished in 2013 and 2014 to not less than 100 percent of the Medicare rates for similar services.[10] HHSC projects that the required rate increase will cost Texas approximately $631 million/year.[11] Because of the difficulties inherent in reducing provider reimbursement rates, HHSC assumes in its projections that the rate increase would continue beyond the two-year period delineated in the law.

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[10] PPACA, § 1202.

[11] These projections were developed by HHSC Strategic Decision Support staff (HHSC SDS) based on claims information maintained by the TMHP's Medicaid Acute Care Claims Payment System.

Loss of Prescription Drug Rebate Revenue

PPACA modifies the minimum Medicaid federal unit rebate amount for most drugs.[12] These modifications were made retroactively effective to January 1, 2010, and have the effect of reducing the supplemental rebates available to the states.

CMS provided initial guidance to states regarding PPACA's pharmacy rebate provisions on April 22, 2010.[13] In this initial guidance letter, CMS indicated that it would retain the difference between the old and new rebate percentages across the board for all drugs, not just for those drugs for which there is an actual increase in the federal rebate amount due to the Act.

Texas Medicaid requested that CMS revise its position.[14] On July 28, HHSC received draft guidance that proposed two options for calculating the federal recapture of the federal rebates.[15] The new approach proposed by CMS would limit the rebate amount that is recaptured by CMS to the amount of increase attributable to PPACA.

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[12] PPACA, § 2501.

[13] *See* State Medicaid Director Letter #10-006, available at http://www.cms.gov/smdl/downloads/SMD10006.pdf, last visited September 2, 2010.

[14] *See* Attachment 4, Letter from Thomas Suehs to Kathleen Sebelius, dated June 1, 2010, concerning Medicaid drug rebate programs.

[15] *See* Attachment 5, *CMS Draft Guidance Document*, Methodology for Calculating the Estimated Quarterly Rebate Offset Amount.

HHSC currently estimates that Texas will lose approximately $70.4 million in rebate revenue from January 2010-August 2013.[16] During that same timeframe, the state will receive approximately $1.5 billion in rebate revenue.[17]

Intrastate Insurance Exchange

PPACA requires Texas to establish one or more Health Insurance Exchanges, or the federal government will do so.[18] An Exchange must be operated by a governmental entity or non-profit organization. If, by January 1, 2013, the federal government determines that Texas will not be ready to operate an Exchange by January 1, 2014, the federal government will designate an entity to operate an Exchange for the State. Texas is exploring whether to establish one or more Exchanges.

No single entity has been designated to design or operate an Exchange if Texas opts to do so. We anticipate receiving further direction the establishment and operation of the Exchange when the Texas Legislature meets from January - May 2011. In the meantime, HHSC and the Texas Department of Insurance (TDI) are coordinating preliminary Exchange planning activities.

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[16] These projections were developed by HHSC Forecasting staff based on information from the Texas Medicaid Vendor Drug claims extract file maintained by FirstHealth, HHSC's pharmacy claims administrator, and the rebate estimate analysis prepared by HHSC Forecasting.

[17] *Id.*

[18] PPACA, § 1311.

If Texas chooses to establish an Exchange, HHSC will incur costs associated with Exchange planning and operations. HHSC's eligibility and enrollment experience will be necessary to begin to plan and estimate costs for the eligibility and enrollment infrastructure required for the Exchange. In addition, regardless of which entity operates the Exchange in Texas, HHSC will be responsible for closely coordinating with the Exchange for streamlined eligibility and enrollment for the Exchange, Medicaid and CHIP. HHSC also will be involved in outreach to vulnerable populations who may be eligible for Medicaid, CHIP, or Exchange subsidies and cost sharing assistance.

For the purposes of estimating costs to develop and operate the Exchange, and pending federal guidance, HHSC has taken the lead in analyzing and estimating costs associated with: eligibility and enrollment; subsidy determination; premium payment; and eligibility-related customer service functions. HHSC expects significant planning and system development efforts from 2011-2013 in order to be ready to operate an Exchange by January 1, 2014.

Medicaid Eligibility Expansion

PPACA expands Medicaid eligibility to all individuals under 65 with incomes of up to 133% of the Federal Poverty Level (FPL).[19] Based on 2008 Census Bureau statistics, Texas has 6,500,000 uninsured residents. Of those, 2,145,000 Texas citizens have incomes below 133% of the FPL.[20]

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[19] PPACA, § 2001(a).

In Texas, this expansion means that several new populations will be eligible for benefits, including: parents and caretakers with incomes from 14% to 133% of FPL; childless adults up to 133% of FPL; foster-care recipients through age 25; and emergency Medicaid in expansion populations. Texas anticipates caseload growth as a result of these newly eligible individuals as well as individuals who are currently eligible for services but not enrolled.

The expansion of Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level will increase Texas's costs, less so in the early years but more so after 2016. HHSC projects PPACA will increase the state's costs by $1.0 billion / year between 2014 and 2016. This will increase to an estimated $2.1 billion/year between 2017 and 2019. Between 2020 and 2023, HHSC projects the state's costs will run to approximately $4.4 billion/year.[21]

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional

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[20] Information provided by HHSC SDS, based on data from the U.S. Census Bureau, March 2009 Current Population Survey – Texas Sample – 2008 figures.

[21] These projections were developed by HHSC SDS based on data from the U.S. Census Bureau, March 2009 Current Population Survey – Texas Sample – 2008 figures and TMHP, Medicaid Acute Care Claims Payment System.

information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 4 2010, in Austin, Texas.

BILLY R. MILLWEE
Texas State Medicaid Director

UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-6

STATE OF TEXAS
COUNTY OF TRAVIS

DECLARATION OF ROBERT KUKLA

Pursuant to 28 U.S.C. § 1746, I, ROBERT KUKLA, declare the following:

"My name is ROBERT KUKLA. I am of sound mind. I have personal knowledge of each of the facts stated herein, and I am competent and authorized to make this affidavit.

I hold the position of Director of Benefit Contracts for the Employees Retirement System of Texas (ERS). Additionally, I have a number of years of professional group insurance underwriting and other insurance industry experience.

My official duties at ERS include managing the Benefit Contracts division of ERS. The division manages the vendors and providers who serve as administering firms within the Texas Employees Group Benefit Program ("GBP"), including, but not limited to, third party administrators and HMOs for GBP health insurance. I oversee all benefit contract areas from procurement to award to contract monitoring, contract compliance and contract enforcement. Benefit Contracts is also responsible for the administration of the Social Security program for all public entities in the State of Texas. In addition, I am familiar with, and it is my official duty to manage the insurance coverage contributions and benefits provided under the GBP and administered by ERS. In the course of my duties, I am responsible for supplying information responsive to legislative inquiries regarding the GBP, among other duties.

The furnishing of the following information is within my official duties and those duties include making an accurate report, which has been done here. All of the statements contained herein are true and correct, and prepared by or received by ERS in the ordinary course of its business.

GBP Eligibility, "full time employees" and waiting periods:

Eligible GBP participants include state officers and employees who perform services for the State of Texas and their dependents, employees and retirees of certain institutions of higher education and their dependents, as specified by Texas Insurance Code Ch. 1551.

Additionally, the Health Select of Texas^{SM} Plan within the GBP is a self-funded health plan. There are also two fully insured HMOs within the GBP for which ERS serves as the plan sponsor. Since at least 1993, the State has paid 100% of the cost of member coverage and 50% of the cost of dependent coverage. Accordingly, any increase or decrease in GBP costs attributable to a member would be borne by the State at 100%, and any increase or decrease in GBP costs attributable to dependent coverage would be split 50%/50% by the State (including higher education) and member, under the current plan.

ERS' statutory waiting period, in Tex. Ins. Code § 1551.104 provides that all "full time" employees are covered automatically by the GBP, subject to a waiting period that is never shorter than 90 days, but may be longer than 90 days, i.e. the first day of the month following the completion of 90 days of service. *Id.* at § 1551.055 (*see also* 24 Texas Administrative Code § 81.5). Under the current General Appropriations Act, the state pays 100% of the insurance contributions for each such employee. *Id.* at § 1551.319(a). All part-time employees are offered an opportunity to enroll as well. Any person working fewer than 40 hours per week is considered to be a "part-time" employee, *Id.* at § 1551.003(11), and must pay one-half of the contribution for coverage, *Id.* at § 1551.319(b). If the part-time employee agrees to pay his or her share of the contributions, then he/she is permitted to enroll in the program.

Impacts of federal health care reform not contained in LAR:

ERS is required to submit estimates and reports relating to appropriations requested by the Texas Legislative Budget Board (LBB) or under the board's direction. In May, 2010, the LBB instructed ERS to prepare and submit its Legislative Appropriations Request for Texas State Fiscal Years 2012-2013 (September 1, 2011 to August 31, 2013) (hereinafter the "LAR"). The LBB instructions required ERS to estimate the budgetary impact to the GBP of federal health care reform: Patient Protection and Affordable Care Act of 2010 ("PPACA;" Public Law 111-148), and the Health Care and Education Reconciliation Act of 2010 ("HCERA;" Public Law 111-152)(collectively referred to as "federal health care reform" and/or PP ACA).

Various expected cost impacts of federal health care reform were supplied to the LBB by ERS as required. *See* Declaration of Michael Wheeler, ERS Chief Financial Officer; *see also,* Declaration of Philip S. Dial, FSA, Rudd and Wisdom, Inc., ERS consulting actuary.

However, based on the limited, specific instructions the LBB requested for the LAR, such as the specific state fiscal years to be included, and with LBB recognition of uncertainties in federal health care reform, the following federal health care reform provisions were not addressed in the LAR. If the following provisions are applicable to ERS and no exceptions apply, ERS expects at least the following requirements to have a negative cost impact to the GBP, though ERS has not estimated exact figures and/or has insufficient information to do so at this time:

Reporting:

If ERS is a group health plan providing minimum essential coverage and the federal health care reform "reporting" provisions [PPACA Sec. 1501 *et seq.*] require ERS or its third-party administrator(s) to issue statements to individuals about coverage, those requirements would require ERS to incur costs or pay its contractors to prepare such reports and statements. Those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership.

Broader Automatic enrollment:

As described above, if ERS is subject to the automatic enrollment of "full time" employees as defined by federal health care reform, ERS expects the GBP to incur costs when additional participants are automatically enrolled who might otherwise not elect to be enrolled, and/or possibly be subject to the application of potential) penalties if it fails to automatically enroll these employees as defined by federal health care reform. Those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership.

Insurance Exchange:

If ERS is subject to the various federal health care reform requirements for insurance exchange(s) [PPACA Sec. 1301 *et seq,* 1402], such as but not limited to establishing the health insurance exchange, participating in the exchange, being assessed penalties for (potentially) not offering qualified coverage, providing notice to individuals, etc., ERS expects the GBP to incur costs and/or possibly be applied fines. Too little is known about the exchange, and those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership.

Rescissions:

If ERS is subject to the federal health care reform prohibitions of group health plan coverage rescissions once an enrollee is covered, except in cases of fraud or material intentional misrepresentation [PPACA Sec. 2712], ERS expects the GBP to incur costs because the GBP currently provides for rescission in cases of negligence and mistake for coverage that would otherwise be rescinded but for federal health care reform. Those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership. Independently, the GBP cannot reliably estimate the number of future expected cases of negligence or mistaken coverage.

Evidence of Insurability:

If ERS is subject to the federal health care reform evidence of insurability prohibitions [PP ACA Sec. § 1201 amending PHSA § 2705] and those prohibitions apply to ERS late enrollees as defined by the GBP, which is unclear to ERS,

ERS would expect the GBP to incur costs because the GBP currently screens late enrollees for evidence of insurability. Those costs have not been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership. Independently, the GBP cannot reliably estimate the number of late enrollees who would have otherwise been excluded for lack of evidence of insurability.

Grandfathered Status:

ERS has not determined grandfathered status and/or made elections to modify or revoke any plan changes that would result in loss of grandfathered status as permitted by federal health care reform [PP ACA Sec. § 1251(e)] on or before August 31, 2011. ERS expects that any GBP loss of grandfathered status would result in additional cost to comply with federal health care reform that would have otherwise been grandfathered. The loss of grand fathered status has not been confirmed by ERS, nor have all costs of any such loss been calculated or estimated for the GBP and/or require input or direction from Texas legislative leadership.

I reserve the right to amend my testimony, as permitted by the Court, if additional federal regulations or guidance is issued, and/or costs become known to ERS and/or relevant input or direction from Texas legislative leadership is received to permit various calculations and estimates.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 29th day of September, 2010.

Robert Kukla, Director of Benefit Contracts
Employees Retirement System of Texas

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-6

DECLARATION OF NEAL T. GOOCH

1. **Pursuant to 28 U.S.C. § 1746, I, Neal T. Gooch, being first duly sworn upon oath, declare as follows:**

2. **I have personal knowledge of the matters set forth in this Declaration.**

3. **I am and since May 19, 2010 have been the Utah Insurance Commissioner. Under the Utah Insurance Code (Title 31A, Utah Code Ann.), the Commissioner is the chief officer of the Utah Insurance Department ("Department").**

4. **From about September 1, 1997 to January 15, 2010, I served as Utah's Deputy Insurance Commissioner.**

5. From January 15, 2010 to May 19, 2010 I served as Utah's Acting Insurance Commissioner.

6. Since the enactment of the Patient Protection and Affordable Care Act ("PPACA") on March 23, 2010, the focus of the Utah Insurance Department has been to understand PPACA and its impact on the work of the Department and the Utah insurance market.

7. The director of the Utah Insurance Department's Health Insurance Division has had to allocate a substantial portion, if not the principal amount of her work schedule toward identifying which provisions of PPACA relate to the insurance market in Utah and developing a strategy to prevent affected Utah insurance statutes from being preempted by PPACA so that the regulation of insurance will remain under my jurisdiction.

8. The most immediate impact of PPACA arises from the provisions in PPACA related to changes in insurance coverage in the insurance market. These changes required the department to reallocate some of its resources in the Health Insurance Division, the Producer Licensing Division, the Market Conduct Division and the Property and Casualty Life Division to meet the demands of PPACA.

9. Because of the enactment of PPACA, the individuals in the Utah Insurance Department's Health Insurance Division have had to triage their work and work only on PPACA implementation and only address non-PPACA matters that are critical to the welfare of the

current market. This has limited their ability to perform their duties as set forth in the Utah Insurance Code.

10. The two (2) full-time employees at the Utah Insurance Department's Office of Consumer Health Assistance, who are tasked with educating the public on insurance matters and assisting them with non-PPACA complaints and inquiries relating to insurance companies and coverage, have also had to limit their work on their statutorily mandated job assignments because they have been spending substantial time on PPACA.

11. The fiscal impact on the Utah Insurance Department's General Fund appropriation arising from reallocating resources within the Department to perform PPACA related duties is $628,000 per year.

Reinsurance Program - PPACA § 1341

12. The situation is similar for the reinsurance mandates of PPACA. In 2009, it is estimated that the State of Utah had 302,400 uninsured individuals. It is estimated that 10% of those individuals would be classified as being uninsurable and will therefore be considered uninsurable or high risk individuals under PPACA. PPACA will require these 302,400 individuals to be to be insured in the market place and that the risk of the 30,000 high risk individuals in the State of Utah risk is to be managed with a risk adjustment mechanism specified in PPACA. This risk adjustment function will require an agency to administer

the risk allocation among insurance companies that is required by PPACA. It is estimated that such an agency will require a significant number of full-time employees and other costs to staff the operations of such an agency.

13. The cost to the Department's General Fund appropriation of establishing and operating such an agency to administer and implement the risk adjustment system associated with the federally mandated health exchange system and is estimated to be $2,008,900 per year.

Premium Review Process

14. Another impact of PPACA is that it requires the Department to change the form and rate regulation and review scheme and process in regard to health insurance products that will be required to be offered both in and out of the exchange mandated by PPACA. Current law is a file and use statutory scheme. Products offered in the mandated federal exchanges will have to be filed, reviewed and certified before they can be used in the exchange. This will create a dual system and require the Department's rate and form analysts to be trained to apply the requirements imposed upon the policy form and rate review process by PPACA. For the rate review after the federal grants terminate, the state will have to fund the costs imposed by the new review process. The additional burden for certification of health insurance policy forms will be bourn fully by the State. We estimate those costs to the department's General Fund appropriation be $1,501,100 per year.

Health Insurance Exchange

15. Currently, the State of Utah has a Health Insurance Exchange organized in the Governor's Office of Economic Development. This exchange, organized as an independent effort by the State to mitigate the costs of the health insurance premiums to its residents, does not include many of the functions and services mandated under PPACA. As a result, I anticipate that the cost to the State of Utah in implementing the requirements of PPACA for its Health Exchange will be significant. It is my understanding that to make the current health exchange compliant with PPACA, the exchange will need a call center, administrative functions, program functions and technology and other functions that are currently not part of the regulatory oversight scheme of the industry or government and will require a full time staff to provide the services and regulation required under PPACA.

DATED this 2nd day of September, 2010.

Neal T. Gooch
Utah Insurance Commissioner

STATE OF UTAH
COUNTY OF SALT LAKE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-6

DECLARATION OF DAVID N. SUNDWALL, M.D.

STATE OF UTAH
COUNTY OF SALT LAKE

I, David N. Sundwall, M.D., being first duly sworn, declare as follows:

1. I am over the age of twenty-one and am familiar with the facts set forth herein.
2. I am a physician licensed to practice in the State of Utah.
3. I am the Executive Director of the Utah Department of Health, the single state agency

operating the Medicaid program in the State of Utah.

4. I am responsible for the preparation of the budget of the Medicaid program and am personally familiar with the records that support the assertions in this affidavit.

5. Utah joined the federal Medicaid program shortly after it was created by Congress in the 1960s. In 1981 the Utah Legislature enacted the "Medical Assistance Act" in Title 26, Chapter 18 of the Utah Code.

6. The Utah Legislature requires the Medicaid program to be operated in the most economical and cost-effective manner possible. Utah Code Ann. § 26-18-2.3 (l)(c) (Supp. 2010).

7. Utah's continued participation in the Medicaid program is based on the expectation that the terms of its participation would not be altered significantly by the federal government to increase the control of the federal government and to reduce Utah's discretionary authority.

8. The Patient Protection and Affordable Care Act ("the Act") expands eligibility for enrollment beyond Utah's ability to fund its participation. Under existing eligibility criteria, individuals applying for Medicaid must be under an income threshold, be under an asset threshold, and fit into a category of need (i.e., disabled, pregnant, etc.).

9. The Act increases the income threshold, eliminates the asset threshold, and eliminates categories of need. As a result, all Utahns under

133% of the federal poverty level (about $30,000 for a family of four) will qualify for Medicaid beginning January 1, 2014.

10. Utah projects this will result in at least 110,000 new individuals enrolling in Medicaid at that time. The current average monthly enrollment is about 210,000 individuals.
11. The costs for these "newly eligible" enrollees will be covered by 100% federal funds for the first three years of the expansion. But that federal participation erodes to 90% in 2020.
12. The Act's new mandate for individuals to maintain health insurance coverage will create an increased incentive for families currently eligible but not enrolled in Medicaid to enroll. Utah will have to cover the costs of this increased enrollment at the traditional match rate: about a 70/30 federal-state split.
13. Medicaid and Children's Health Program outlays for Utah consume 19% of Utah's budget.
14. For FY 2009-2010, Utah spent $230 million in state funds on Medicaid. The projected increases in state funds needed for Medicaid under the Act are $37 million in 2014, eventually growing to $157 million in 2021.
15. The Act therefore forces Utah to increase state funding for these programs from current levels by 16% in 2014, increasing year by year to 68% in 2021.
16. It would not now be feasible for Utah to cease its participation in Medicaid and make alternative

arrangements for a traditional Medicaid-like program prior to the Act taking effect.

17. The added costs to Utah under the Act would not be offset by increased federal contributions under the Act.

18. The Act also will also require Utah to provide medical services, as distinguished from providing payment for medical services. The future costs to the state of this mandate are potentially massive, but have not yet been quantified.

DATED this 2nd day of September, 2010.

David N. Sundwall, M.D.
Executive Director
Utah Department of Health

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/04/10
DOCUMENT NO.: 80-9

DECLARATION OF JERRY DUBBERLY

Pursuant to 28 U.S.C. § 1746, I Jerry Dubberly, declare the following:

I am over the age of twenty-one and am familiar with the facts set forth herein.

I am a pharmacist licensed to practice in the State of Georgia.

I am the Medicaid Director of the Georgia Department of Community Health, the single state agency operating the Medicaid program in the State of Georgia.

I am responsible for the preparation of the budget of the Medicaid program and am personally familiar with the records that support the assertions of this affidavit.

Georgia joined the federal Medicaid program shortly after it was created by Congress in the 1960s. In 1981, the Georgia General Assembly created the Department of Community Health in Title 31, Chapter 2 of the Georgia Code.

The Patient and Protection Affordable Care Act (the "PPACA") expands eligibility for enrolment beyond Georgia's current ability to fund its participation. Under existing eligibility criteria, individuals applying for Medicaid must be under an income threshold, be under an asset threshold, and fit into a category of need (i.e., disabled, pregnant, etc.).

The Act increases the income threshold, eliminates the asset threshold, and eliminates categories of need. As a result, all Georgians under 133% of federal poverty level (about $30,000 for a family of four) will qualify for Medicaid beginning January 1, 2014.

Georgia projects this will result in a least 560, 769 new individuals enrolling in Medicaid at that time. The current average monthly enrollment is about 1,477,838.

The costs for these newly eligible enrollees will be covered by 100% federal funds for the first three years of expansion. But that federal participation erodes to 90% in 2020.

The Act's new mandate for individuals to maintain health insurance coverage will create an increased incentive for families currently eligible but not enrolled in Medicaid to enroll. Georgia will have to cover the costs of this increased enrollment at the traditional match rate: approximately 65/35 federal-state split.

Medicaid and Peachcare for Kids outlays for Georgia consume 11.8% of Georgia's current budget. The portion of the state budget dedicated to health care is projected to increase to approximately 14.3% by 2014.

It is estimated that there will be a 31.7% increase in Medicaid and PeachCare for Kids membership due to the PPACA beginning in 2014.

For FY 2009-2010, Georgia spent $1.733 billion in state funds on Medicaid benefits. The projected increases in state funds needed for Medicaid under the Act are $71.2 million in 2014, eventually growing to $410.8 million in 2019.

It would not now be feasible for Georgia to cease its participation in Medicaid and make alternative arrangements for a traditional Medicaid-like program prior to the PPACA taking effect.

The added costs to Georgia under the Act would not be offset by increased federal contributions under the PPACA.

The PPACA also will required Georgia to provide medical services, as distinguished from providing payment of medical services. The future costs to Georgia of this mandate are potentially massive, but have not yet been quantified.

DATED this 4th day of November, 2010.

Jerry Dubberly
Medicaid Director
Georgia Department of Community Health

State of Georgia
County of Fulton

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

FURTHER DECLARATION OF VIVIANNE M. CHAUMONT

Pursuant to 28 U.S.C. § 1746, I, Vivianne M. Chaumont, being first duly sworn, hereby depose and state as follows:

1. **My name is Vivianne M. Chaumont. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration.**

2. **I am the Director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services (Nebraska DHHS). My responsibilities include the administration of the Medicaid program**

which is subject to requirements of state and federal regulatory and statutory authority. Neb. Rev. Stat. § 68-904 to 906; Title XIX, 42 USC 1396a, et seq.

3. I am making this further declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Nebraska is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

4. I earlier provided an affidavit in this matter describing the impact the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA) would have on the Nebraska Medicaid program. That impact was analyzed by Milliman, Inc., an actuarial firm specifically retained by Nebraska DHHS for that purpose.

5. Since providing the aforementioned affidavit, Milliman has provided an updated written analysis of the impact of that federal law as it pertains to DHHS and the State's Medicaid program. A true and correct copy of the updated version of the report, with revised analysis, is attached and marked as Exhibit A.

6. The updated written analysis provided by Milliman was necessitated by a September 28, 2010 letter from the Centers for Medicare & Medicaid Services to state Medicaid directors, which revised previous instructions concerning the federal offset of Medicaid prescription drug rebates.

7. Based upon Milliman's updated written analysis and Nebraska DHHS records and projections prepared and maintained in the regular course of state business, I estimate that the PPACA will cost Nebraska between $458.2 million and $691.5 million for the period of Fiscal Year 2011 through Fiscal Year 2020. See Exhibit A.

8. I have reviewed Defendants' claim that the PPACA will save the State of Nebraska $36 million per year, which is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

9. The State of Nebraska does not stand to save $36 million due to the savings elements described in the CEA report.

10. Defendants erroneously attribute savings by local governmental units to the State of Nebraska. CEA Report at 67-68. On the contrary, any savings realized by local governments from persons who newly enroll in Medicaid would actually increase costs for the State of Nebraska.

11. The CEA Report upon which Defendants rely also erroneously assumes the elimination of uncompensated care in Nebraska in the amount of $8.6 million ("Hidden Tax" estimate), CEA Report at 68, which is contrary to any known projections familiar to Nebraska DHHS. The CEA Report also bases this estimate on costs borne by both state *and local* governments. As a result, it is not accurate to attribute the full $8.6

million savings estimate to the State of Nebraska alone.

12. The CEA Report's "Hidden Tax" estimate is also likely overstated for another reason. Hospitals which report higher than average (disproportionate share (DSH)) uncompensated costs are eligible to receive payments to help defray those costs, if they otherwise qualify. As a result, part of this uncompensated care for the uninsured is currently being paid through the DSH program, which includes state and federal funding. Not all of the cost is absorbed into the higher premiums referenced in the CEA Report's "Hidden Tax" section. The DSH program will be phased out over time as uncompensated costs go down. However, there is no assurance that the higher employee health insurance premiums will be going down. Likewise, the CEA Report says that there "may" be increased enrollment that will "potentially" allow cost savings to the states.

13. The CEA Report upon which Defendants rely forecasts that additional savings "may come" from the Children's Health Insurance Program. CEA Report at 68. However, under the PPACA, no changes to eligibility regarding CHIP can be made until 2019. The current eligibility level for CHIP in Nebraska is 200%, which is higher than the 133% provided by the PPACA. There is no mechanism in place for the State to manage or reduce this cost.

14. The $36 million figure relied on by the Defendants from the CEA Report also is based

upon the federal government's provision of a 100% FMAP (CEA Report at 6, 70). As passed, however, the ACA does not provide for an indefinite 100% FMAP, but a federal contribution that decreases to 90% by 2019.

15. The CEA Report also states that the State of Nebraska and local governments spend at least $36 million on care for the uninsured, and estimate that the annual cost of Medicaid expansion to Nebraska's low income uninsured individuals would be $178 million, with Nebraska's share being approximately $18 million. However, the CEA Report bases its $178 million estimate on the number of low income uninsured individuals expanding equal to 55,345.

16. Based upon the updated analysis of Milliman, the number of low income uninsured individuals is likely to expand by far more than 55,345, as the CEA Report assumes. Instead, Milliman's analysis takes into account individuals who have the potential to enroll and estimates that enrollment will be at least 107,903 individuals, and possibly as high as 145,297 individuals (see Exhibit A), thus raising the cost to Nebraska.

17. Finally, the CEA Report bases its conclusions on income levels of 133% of the federal poverty line, not 133% with a 5% disregard, as included in the PPACA. As a result, the CEA Report does not reflect the current eligibility levels contemplated by the PPACA.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Vivianne M. Chaumont
Director, Division of Medicaid and Long-Term Care
Department of Health and Human Services
Date: 11/22/10

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

DECLARATION OF ROBERT D. CHURCH, JR.

Pursuant to 28 U.S.C. § 1746, I, Robert D. Church, Jr, declare the following:

1. My name is Robert D. Church, Jr. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Alabama Medicaid Agency as the Commissioner of the Agency and as the Chief Financial Officer.

2. I have served as Chief Financial Officer since approximately November, 2009 and as Commissioner since November, 2010.

3. As Commissioner, I am the highest ranking official in the Alabama Medicaid Agency and am responsible for all activities of the Agency including the operation of the Medicaid program.

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Alabama is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. Presently, Alabama Medicaid Agency has projected that the initial administrative cost to the state will total over $76,000,000 by the conclusion of state Fiscal Year 2015 as a result of the passage of PPACA. This amount increases going forward, and by 2018 the projected administrative costs to Alabama are estimated to be in excess of $35,000,000 annually from the state's general fund. There are, currently, no projected savings as a result of PPACA.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 19, 2010, in Montgomery, Alabama.

Robert D. Church, Jr.
Commissioner
Alabama Medicaid Agency

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

DECLARATION OF ROBERT M. DAMLER

Pursuant to 28 U.S.C. § 1746, I, Robert M. Damler, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law:

1. I am making this further declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Indiana is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

2. I am a Principal and Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

3. Indiana Code § 12-8-1-7 gives the secretary of the Indiana Family and Social Services Agency (FSSA) the power to employ experts and consultants to carry out the duties of the secretary and the offices. Under this power, the Secretary of FSSA hired Milliman, Inc. to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act (H.R. 3590) as it relates to the provisions impacting the State's Medicaid program and budget.

4. I provided a declaration earlier in this matter certifying the authenticity of a report I provided to FSSA concerning PPACA's impact on the Medicaid program. That report is attached as Exhibit A to the declaration of Pat Casanova, the head of the Indiana Office of Medicaid Policy and Planning, which declaration was supplied as Exhibit 10 in support of the Plaintiffs' Motion for Summary Judgment. I am the principal author of that report.

5. In my report dated October 18, 2010 to FSSA, I projected that PPACA is likely to increase the Indiana expenditures on the Medicaid program to be between \$2.6 billion and \$3.1 billion through state fiscal year 2020. The FSSA report did not reflect savings to other areas of the Indiana budget.

6. I have reviewed Part II.C.1 of the memorandum filed on November 4, 2010, by the United States Department of Health and Human Services in support of its motion for summary judgment in this matter and Exhibit 33 thereto.

7. On pp. 39-41 of DHHS's summary judgment memorandum, DHHS claims that the PP ACA will save the State of Indiana millions of dollars per year. This claim is based on Exhibit 33 to DHHS's motion for summary judgment, a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009, and titled *The Impact of Health Insurance Reform on State and Local Governments* (CEA Report).

8. There are several assumptions used in the DHHS's calculations that are not consistent with the actual experiences of the State of Indiana. Under PP ACA, the State of Indiana would not be expected to save $338 million per year compared with current State indigent care programs (as described in the CEA report), but instead may incur an additional $50 million per year or more compared with current outlays for indigent care programs.

9. Page 34 of the CEA Report at Exhibit 33 presents an estimated annual increased Medicaid cost for Indiana of $62 million based on a Federal Medical Assistance Percentage (FMAP) of 90%. This calculation is based on adding to the State's Medicaid rolls 189,000 currently uninsured adults and parents at a cost of $2,974 per person per year, and 31,600

currently uninsured children at a cost of $1 ,898 per child per year. This equates to a total combined State and Federal outlay of $563 million for adults and parents and $60 million for children each year. My analysis shows that the CEA's estimated cost for parents and adults is too low at $2,974 per year. My estimate, based on Indiana-specific data of the actual age and gender of the uninsured population, with adjusted morbidity, would be approximately $3,600 per year, which is 21% greater than the CEA's $2,974 value. As a further comparison, the Kaiser Commission on Medicaid and the Uninsured report titled, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL" utilized an average cost for Indiana for the period of2014 to 2019 estimated to be $4,300 to $5,000. These values are estimates since full details were not published in the report.

10. Furthermore, the CEA's estimated annual increased Medicaid cost for Indiana in Exhibit 33 did not account for any parents or adults that are currently *insured* but who are likely to switch to the Medicaid program once that becomes available. My previously published estimate anticipates an additional 107,000 currently insured adults and parents will enroll in the Indiana Medicaid program, which is more than a 50% increase to the CEA's estimate of parents and adults likely to join the Indiana Medicaid program. In addition to my previously published estimates, the Kaiser Commission report previously referenced 216,000 to 338,000

uninsured adults and parents will be enrolled in Medicaid by 2019. In addition to the previously uninsured enrollment, the Kaiser Commission report anticipates total adult and parent Medicaid enrollment to expand by 298,000 to 427,000 including both the uninsured and insured populations.

11. The CEA's estimates were based on earlier versions of health care reform legislation that would have expanded Medicaid eligibility to 133% of the Federal Poverty Level (FPL), which is not consistent with the final PPACA legislation. While PPACA specifies an income threshold of 133 percent of FPL for the Medicaid expansion, it also requires states to apply an "income disregard" of 5% of FPL in meeting the income test. Therefore, the effective income threshold is actually 138% of FPL. *See* Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services memorandum, April 22, 2010, at https://www.cms.gov/ActuarialStudies/Downloads/PP ACA 201 0-04-22.pdf (November 4, 201 0).

12. Adjusting the CEA estimate for the higher cost per recipient noted in paragraph 9 above (a 21% increase), the likelihood that currently insured adults and parents will switch to Medicaid under the new PPACA standards noted in paragraph 10 (a 50% increase), and the expanded Medicaid population at the higher FPL noted in paragraph 11 (a 5% increase), the Adult/Parent Population would cost an estimated $1,072 million (State and Federal

contribution combined) or $107 million State contribution at 90% FMAP. The $107 million State contribution would compare to the $56.3 million illustrated by the CEA.

13. The CEA calculations need further modifications. First, the illustration applied the 90% FMAP to the children population, which would not be appropriate. Rather, this population will receive the standard FMAP, which is approximately 66% for Indiana in FFY 2011. This 34% State contribution for children means that the State portion of the Medicaid increase will be $20 million, not $6 million as the CEA estimates on page 37, Table 2 of Exhibit 33. With this correction, the total estimate of the State's increased Medicaid exposure would be $127 million, as compared to the $62 million the CEA has estimated in Exhibit 33.

14. Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive provisions of major health and welfare programs authorized under the Act, thus allowing states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under federal rules. Indiana received such a waiver for the Healthy Indiana Plan. Because of the waiver, in addition to adjusting the FMAP on the children population, the State of Indiana may incur lower FMAP on a portion of the expansion population. Indiana may lose the enhanced FMAP of 90% on the first 34,000 lives, which corresponds to the number of childless adults that are allowed under Indiana's Section 1115 waiver for the

Healthy Indiana Plan. Although a final decision has not been provided by CMS, the loss in the enhanced FMAP would have a significant financial impact on the Medicaid Assistance budget. The 24% reduction in FMAP yields an additional $75 million cost for Indiana per year of Federal funds. This would be added to the $127 million value noted in paragraph 13.

15. The CEA's illustrations for Indiana m Exhibit 33 also does not include an estimate for administrative costs for enrollment, claims processing, and other administrative functions of serving an additional 300,000 lives. The administrative costs are generally matched at 50% Federal share/50% State share. We estimate that state share of these administrative costs would be $28 million per year.

16. After accounting for the modifications listed in paragraphs 12-15 above, Indiana's share of increased Medicaid costs under PPACA may be estimated at nearly $230 million per year, as compared to CEA illustrated amount of $62 million per year.

17. Another aspect that is unique to Indiana and other state Medicaid agencies relates to the disabled population eligibility requirements. The State of Indiana operates as a Section 209(b) state, which allows the State of Indiana to have different disability eligibility criteria. Since Indiana is a Section 209(b) state, it also provides eligibility under a spend-down provision requiring recipients to spend down their excess

monthly income toward medical expenses before they are eligible for Medicaid. Due to this eligibility determination rule, there are approximately 22,000 individuals that are SST disabled that do not qualify for the Medicaid disability eligibility in Indiana. Although CMS has not yet provided a final determination, Indiana may not receive the enhanced FMAP for these additional individuals under the new eligibility provisions of ACA. To the extent that the standard FMAP applies to the disabled population, the additional cost to the State of Indiana would be $90 million per year. It does not appear that the CEA estimate included an adjustment for this population. By combining the annual cost savings noted in this paragraph of $90 million with the total of $230 million in paragraph 16, the cost could be re-stated as $320 million.

18. Exhibit 33 also over-estimates cost savings that Indiana is likely to realize as a result of the Medicaid Expansion. For example, the CEA has illustrated a value of $154 mill1on for the cost of the Healthy Indiana Plan. These funds may be diverted beginning in January 1, 2014, to assist in covering the cost of the Medicaid expansion. However, the State's actual commitment to the Healthy Indiana Plan is limited by the amount of the State's Cigarette Tax revenues that the General Assembly has allocated to HIP. The current annual revenue has been approximately $125 million per year, rather than the $154 million illustrated by the CEA.

19. Exhibit 33 also illustrates a savings of $126 million per year through the Hospital Uncompensated Care for the Indigent (HCIP) program. However, CEA inadvetlently illustrated the biennial budget amount for HCIP rather than the single year value. The actual annual savings for canceling HCIP in light of expanded Medicaid under PP ACA would be $63 million per year.

20. The CEA report also *under*estimates cost savings the State may realize from cancelling its high-risk pool ICHIA program. The CEA estimates that the State currently spends about $15 million annually on that program, but annual outlays are closer to approximately $40 million per year.

21. By combining the annual savings figures noted in paragraphs 18, 19 and 20 ($125M + $63M + 40M), the savings would be re-stated at approximately $228 million per year from these three sources rather than the $296 million estimated by CEA on page 38, Table 3 of Exhibit 33.

22. The differences between our estimates for Indiana and CEA's estimates are illustrated in the following table:

	Milliman/ Indiana	CEA, Exhibit 33 at Table 3
Medicaid Expansion	$(320)M	$(62)M
Healthy Indiana Plan	$125M	$155M
ICHIA	$40M	$15M
Tax Credit	$12M	$12M
HCIP	$63M	$126M

Hidden Tax	$30M	$30M
Net Impact	$(50)M	$275M

Note: Values have been rounded to millions.

23. There are further qualifications of these amounts. HCIP, for example, is not a stand-alone state program, but is instead part of Indiana's Medicaid Plan. Accordingly, Indiana will actually continue to incur the full cost of HCIP even as it assumes greater costs for expanded Medicaid coverage under PPACA. So, reducing that savings line item to zero, Indiana's Medicaid exposure will actually be near $113 million.

24. It is also important to observe that, while Medicaid expansion costs are in today's dollars which will inflate over time, the State's revenue stream currently dedicated for funding HIP and HCIP, the Indiana Cigarette Tax, will not. In fact, since Indiana's Cigarette Tax increased to 44 cents per pack and an additional federal cigarette tax has been implemented, Cigarette Tax revenue has decreased as more and more smokers quit smoking. That revenue stream is, thus, highly unlikely to keep pace with inflation, meaning that Indiana will have to find other revenue sources to pay its share of the expanded Medicaid program that is mandated by PPACA, not by its own program decisions.

25. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 18th day of November, 2010.

Robert M. Damler, MAAA,
Principal and Consulting Actuary,
Milliman, Inc.,
111 Monument Circle, Suite 601,
Indianapolis, Indiana 46204

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

FURTHER DECLARATION OF ELIZABETH DUDEK

Pursuant to 28 U.S.C. § 1746, I, Elizabeth Dudek, declare the following:

1. My name is Elizabeth Dudek. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida Agency for Health Care Administration (AHCA) as the Interim Secretary.
2. I have served as Interim Secretary since September 2010.
3. As the Interim Secretary, I am the highest ranking official in AHCA and am responsible for

all activities of the Agency including the operation of the Medicaid program.

4. The facts and statements in this further declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. I previously provided a declaration in this matter describing the projected impacts of the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA) on the Florida Medicaid program. As I stated in that declaration, AHCA projects that PPACA will cost the Florida Medicaid program $142,460,765.00 in state general revenue in Florida's 2013-2014 fiscal year. This amount increases going forward, and by 2018-19 the projected costs to Florida are estimated to be just over a billion dollars per year, or $1,012,206,268.00, in general revenue.

6. I have since reviewed the Defendants' claim that PPACA will save the State of Florida $377 million per year, which appears to be based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

7. The CEA report, however, does not appear to address the impact of the final version of PPACA on the state government of Florida. In fact, at the time the CEA Report was issued in September 2009, PPACA was not yet in its final form. Thus, it appears that the CEA Report only attempted to address possible impacts of PPACA, while guessing at what the national

health care reform effort would look like when it was completed.

8. The Defendants' appear to draw their $377 million savings figure from a column of a chart on page 26 of the Report (the exact figure in the column is $377.2 million). Two assumptions made with respect to this $377 million amount did not come to pass, however, in PPACA's final version. First, the $377 million figure assumes 100% federal financing of Medicaid expansion (CEA Report p. 26). PPACA itself only ultimately provides for 90% federal financing. The state governments, including Florida's, will supply the other 10%. The $377 million figure in the Report thus underestimates the costs to the state government of Florida from Medicaid expansion. Second, the CEA Report appears to assume that, if the national health care reform effort were to be successful, all uncompensated care would disappear. This also did not come to pass in PPACA's final form.

9. Using the CEA Report to forecast savings to the State of Florida also presents other issues. For example, the CEA Report analyzes possible savings to be realized by state *and local* governments taken together. All or virtually all of the $377 million in projected savings described in the report would accrue to local governmental entities such as Miami-Dade County, Hillsborough County, and Duval County. As AHCA Interim Secretary, I have no knowledge regarding any alleged or projected costs or savings to these local governments, and thus cannot testify as to whether the localities

described will realize any net savings from PPACA.

10. The CEA Report, however, appears to project that all uncompensated care in Florida would disappear (which did not actually occur in PPACA's final form), and that local governments will save as a result. CEA Report at p. 24, 26. Uncompensated care is not likely to disappear as a result of PPACA. To the extent uncompensated care diminishes as a result of PPACA, local government savings from its disappearance generally will not result in any savings to the state government's budget. In fact, a reduction in uncompensated care may be at least partially the result of previously uninsured persons enrolling in Medicaid. In other words, any savings realized by local governments from a reduction in uncompensated care might actually increase costs for Florida Medicaid.

11. Finally, the CEA Report forecasts that additional savings ($117 million) "may come" from the Children's Health Insurance Program. (CEA Report at 24-25) My prior declaration included AHCA projections that incorporated the State of Florida's potential for savings related to CHIP (*see* ¶ 20), such that this figure does not discount the annual estimated cost to the State of Florida to which I previously attested (*see* ¶ 5, above).

12. As a result of the factors described above, AHCA stands by the projections contained in my

previous declaration, and will not alter its projections based on the CEA Report.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 18, 2010, in Tallahassee, Florida.

Elizabeth Dudek
Interim Secretary
Agency for Health Care Administration

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

FURTHER DECLARATION OF J. ERIC PRIDGEON

Pursuant to 28 U.S.C. § 1746, I, J. Eric Pridgeon, declare the following:

1. **My name is J. Eric Pridgeon. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida House of Representatives as the Budget Chief for Health Care Appropriations.**

2. **I have served as Budget Chief since 2008. I have 15 years of experience working on Medicaid budget and policy matters at the state level.**

3. As the Budget Chief, I write the annual budget for the Florida Medicaid program. In addition, I serve as a principal for the Social Services Estimating Conference which projects enrollment and costs for the Medicaid program, and monitor Medicaid expenditures and analyze budget amendments throughout the fiscal year. Based on my employment, I am familiar with the Patient Protection and Affordable Care Act (PPACA) and the effects (actual and projected) of the PPACA on Florida's Medicaid program.

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Florida is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. Earlier declarations were provided in this matter by Elizabeth Dudek, Interim Secretary, State of Florida, Agency for Health Care Administration, and by Joanne Leznoff, Staff Director of the Appropriations Committee, State of Florida, House of Representatives. Those declarations attested to the impact of the Medicaid program provided in the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA).

6. I have since reviewed the Defendants' Memorandum in Support of their Motion for Summary Judgment and their claim that the PPACA will save Florida's state and local

governments $377 million per year, which is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

7. Defendants cite several local government programs to arrive at this savings estimate.

8. To the extent that local governments seek to reduce some of the cited expenditures, they could only do so at a cost to the State of Florida.

9. Hillsborough County and Miami-Dade County both participate in funding the Medicaid program along with 20 other local governments that collectively provide over $584 million in intergovernmental transfers – funds that are used for the state Medicaid program.

10. The Hillsborough County and Miami-Dade County funding cited by the CEA Report are incorporated into the Medicaid program because these same sources (in whole or in part) are transferred to the State of Florida and used to draw federal Medicaid matching funds before being paid to hospitals within those counties in support of the local programs and providers described in the CEA Report.

11. Miami-Dade County and Hillsborough County contributed approximately $269 million of the intergovernmental transfers from local governments incorporated into the FY 2010-11 Medicaid budget.

12. Regardless of whether the specific local programs cited in the CEA Report remain intact following implementation of PPACA, the State

of Florida is dependent upon the contribution of local tax dollars to underwrite core costs of the Medicaid program including funding of specific or "exempt" payment rates to select hospitals (e.g. teaching hospitals, children's hospitals, and rural hospitals) and funding for specialty services such as trauma care and pediatric services.

13. The specific payment rates are known as "exempt" rates because these rates are not bound by statutory ceilings established by the Legislature as a way to manage Medicaid hospital expenditures within appropriations.

14. Loss of the local funding, should such a loss result from implementation of PPACA, would cost the State of Florida the equivalent of any "savings" to local government because the availability of essential services funded by intergovernmental transfers would be at risk if payments were reduced to non-exempt rates and funding for specialty services was eliminated.

15. The CEA Report upon which Defendants rely also assumes the elimination of uncompensated care in Florida ($102 million "Hidden Tax" estimate (CEA Report at 24)), which is contrary to the PPACA's own estimate of providing less than universal coverage (PPACA § 1501(a)). The CEA Report also bases this estimate on costs borne by both state *and local* governments, such that it is not accurate to attribute the full $102 million savings estimate to the State of Florida alone. The CEA Report does not set forth all the assumptions used to arrive at this number.

16. Defendants cite John Holahan & Stan Dorn, Urban Institute, *What Is the Impact of the [PPACA] on the States?* (June 2010) at 2 for the proposition that state and local governments would save approximately $70-80 billion over the 2014-19 period by shifting state-funded coverage into federally-matched Medicaid. The Holahan and Dorn report does not set forth all the assumptions used to arrive at this number. The Congressional Research Service (CRS) reports that varying impacts are projected for different states, with one state anticipating some savings, but no offsets are noted. (Six states anticipate more than $38 billion in increased costs.) Memorandum, *Variations in Analyses of PPACA's Fiscal Impact on States* (September 8, 2010).

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 22, 2010, in Tallahassee, Florida.

J. Eric Pridgeon
Budget Chief, Health Care
Appropriations Committee
Florida House of Representatives

UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF FLORIDA
Pensacola Division

No. 3:10-cv-91-RV/EMT

STATE OF FLORIDA, *et al.*,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Defendants.

DATE FILED: 11/23/10
DOCUMENT NO.: 135-1

DECLARATION OF BRUCE R. RAMGE

Pursuant to 28 U.S.C. § 1746, I, Bruce R. Ramge, declare the following:

1. My name is Bruce R. Ramge. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Nebraska Department of Insurance (NDOI) as the Director.

2. I have served as Director of Insurance since November 15, 2010. Previously, I was Acting Director from November 1, 2010 through November 14, 2010. Prior to November 1, 2010, I

served in the capacity of Deputy Director and Chief of Market Regulation.

3. As the Director of Insurance, I am the highest ranking official at the NDOI and oversee all activities of the Agency including the regulatory oversight of the Comprehensive Health Insurance Pool (CHIP).

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Nebraska is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. I reviewed the Defendants' claim that the PPACA will save the State of Nebraska approximately $27 million per year beginning in 2014 when the CHIP program ends with the individuals insured obtaining insurance through a proposed exchange. This is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report, page 67).

6. The State of Nebraska does not subsidize premiums for the CHIP program. Under Nebraska law, the state is required to subsidize claims exceeding the amount collected in premiums from the CHIP members. In 2008, this amount was $27,375,209. In 2009, this amount was $24,051,163.

7. The provisions of PPACA currently anticipate the transfer of CHIP participants to Medicaid or health insurance products offered through a proposed exchange beginning January 1, 2014. A number of factors prevent me from predicting, at this time, the precise impact the transfer of CHIP participants to Medicaid will have on the State of Nebraska in 2014, including: claims in process, incurred but not reported claims, and the remaining administrative and wrap up costs. However, said transfer is not anticipated to be a cost savings for the State of Nebraska due to the additional burden of enrolling such individuals in the Medicaid system.

8. With the influx of CHIP policyholders who may purchase insurance through an exchange, the health insurance premium charged to all persons obtaining coverage through the exchange will necessarily increase to cover high claim individuals. Essentially, the experience of the high claim individuals will be reflected in the price of the premium for individual insurance coverage offered in Nebraska generally resulting in higher premium costs for all participating in an exchange. This results in a cost shift to all citizens of Nebraska purchasing through the exchange via an increase in premium costs.

9. Further, individual coverage in the exchange may become so costly that the CHIP policyholders will not be able to afford it even with a subsidy for which the CHIP policyholder may be eligible. An unknown number of current CHIP policyholders may also qualify for

Medicaid, resulting in an increase in costs incurred by the state.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 19, 2010, in Lincoln, Nebraska.

Bruce R. Ramge
Director
Nebraska Department of Insurance

PETITIONER'S BRIEF

NOS. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, *ET AL.*,

v.

KATHLEEN SEBELIUS, *ET AL.*

STATES OF FLORIDA, *ET AL.*,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*

On Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR STATE PETITIONERS ON SEVERABILITY

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
BLAINE H. WINSHIP
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

January 6, 2012 *(Additional Counsel Listed on Inside Cover)*

THOMAS W. CORBETT, JR.
Governor
LINDA L. KELLY
Attorney General
Commonwealth of
Pennsylvania
16th Floor
Strawberry Square
Harrisburg, PA 17120

MARTY J. JACKLEY
Attorney General
of South Dakota
1302 East Highway 14
Pierre, SD 57501

GREGORY F. ZOELLER
Attorney General of Indiana
302 West Washington Street
Indianapolis, IN 46204

SAMUEL S. OLENS
Attorney General of Georgia
40 Capitol Square, SW
Atlanta, GA 30334

MICHAEL DEWINE
Attorney General of Ohio
DAVID B. RIVKIN
LEE A. CASEY
Baker & Hostetler LLP
Special Counsel
30 East Broad Street
17th Floor
Columbus, OH 43215

JOSEPH SCIARROTTA, JR.
General Counsel
Office of Arizona Governor
JANICE K. BREWER
TOM HORNE
Attorney General of Arizona
1700 West Washington
Street, 9th Floor
Phoenix, AZ 85007

WAYNE STENEHJEM
Attorney General
of North Dakota
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

BRIAN SANDOVAL
Governor of Nevada
State Capitol Building
101 North Carson Street
Carson City, NV 89701

RICHARD SVOBODNY
Acting Attorney General
of Alaska
P.O. Box 110300
Juneau, AK 99811

DEREK SCHMIDT
Attorney General of Kansas
Memorial Hall
120 SW 10th Street
Topeka, KS 66612

Greg Abbott
Attorney General of Texas
Bill Cobb
Deputy Attorney General
for Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

Jon Bruning
Attorney General
of Nebraska
Katherine J. Spohn
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508
(402) 471-2834

Alan Wilson
Attorney General
of South Carolina
P.O. Box 11549
Columbia, SC 29211

Mark L. Shurtleff
Attorney General of Utah
Capitol Suite #230
P.O. Box 142320
Salt Lake City, UT 84114

Luther Strange
Attorney General
of Alabama
501 Washington Avenue
Montgomery, AL 36130

James D. "Buddy" Caldwell
Attorney General
of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804

Bill Schuette
Attorney General
of Michigan
P.O. Box 30212
Lansing, MI 48909

John W. Suthers
Attorney General
of Colorado
1525 Sherman Street,
Denver, CO 80203

Robert M. McKenna
Attorney General
of Washington
1125 Washington Street S.E.
P.O. Box 40100
Olympia, WA 98504

Lawrence G. Wasden
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720

MATTHEW MEAD
Governor of Wyoming
State Capitol
200 West 24th Street
Cheyenne, WY 82002

WILLIAM J. SCHNEIDER
Attorney General of Maine
Six State House Station
Augusta, ME 04333

J.B. VAN HOLLEN
Attorney General of Wisconsin
114 East State Capitol
Madison, WI 53702

TERRY BRANSTAD
Governor of Iowa
107 East Grand Avenue
Des Moines, IA 50319

QUESTION PRESENTED

If the Affordable Care Act's mandate that virtually every individual obtain insurance exceeds Congress' enumerated powers, to what extent (if any) can the mandate be severed from the remainder of the Act?

PARTIES TO THE PROCEEDINGS

Petitioners in No. 11-400, who were the appellees/cross-appellants below, are 26 States: Florida, by and through Attorney General Pam Bondi; South Carolina, by and through Attorney General Alan Wilson; Nebraska, by and through Attorney General Jon Bruning; Texas, by and through Attorney General Greg Abbott; Utah, by and through Attorney General Mark L. Shurtleff; Louisiana, by and through Attorney General James D. "Buddy" Caldwell; Alabama, by and through Attorney General Luther Strange; Attorney General Bill Schuette, on behalf of the People of Michigan; Colorado, by and through Attorney General John W. Suthers; Pennsylvania, by and through Governor Thomas W. Corbett, Jr., and Attorney General Linda L. Kelly; Washington, by and through Attorney General Robert M. McKenna; Idaho, by and through Attorney General Lawrence G. Wasden; South Dakota, by and through Attorney General Marty J. Jackley; Indiana, by and through Attorney General Gregory F. Zoeller; North Dakota, by and through Attorney General Wayne Stenehjem; Mississippi, by and through Governor Haley Barbour; Arizona, by and through Governor Janice K. Brewer and Attorney General Thomas C. Horne; Nevada, by and through Governor Brian Sandoval; Georgia, by and through Attorney General Samuel S. Olens; Alaska, by and through Acting Attorney General Richard Svobodny; Ohio, by and through Attorney General Michael DeWine; Kansas, by and through Attorney General Derek Schmidt; Wyoming, by and through Governor Matthew H. Mead; Wisconsin, by and through Attorney General J.B. Van Hollen; Maine, by and through Attorney General William J. Schneider; and Governor Terry E. Branstad, on behalf of the People of Iowa.

Petitioners in No. 11-393 are the National Federation of Independent Business, Kaj Ahlburg, and Mary Brown, who were also appellees below.

Respondents in both cases, who were the appellants/cross-appellees below, are the U.S. Department of Health & Human Services; Kathleen Sebelius, Secretary, U.S. Department of Health & Human Services; the U.S. Department of Treasury; Timothy F. Geithner, Secretary, U.S. Department of Treasury; the U.S. Department of Labor; and Hilda L. Solis, Secretary, U.S. Department of Labor. The States are also Respondents by rule in No. 11-393, and NFIB, *et al.*, are also Respondents by rule in No. 11-400.

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JURISDICTION

The Eleventh Circuit rendered its decision on August 12, 2011. The States and the private parties filed timely petitions for certiorari, and this Court granted review of the third question presented in the States' petition and of the private parties' petition on November 14, 2011. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The table of contents to and relevant provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, are reproduced in an appendix to this brief.[2]

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[1] For ease of reference, all citations of the Petition Appendix in all briefs arising out of the decision below are of the appendix to the federal government's petition for certiorari in *U.S. Department of Health and Human Services v. Florida*, No. 11-398. Citations of the Eleventh Circuit Record Excerpts are designated "R.E."

[2] All citations of provisions of the "ACA" are of the Affordable Care Act as amended by the Reconciliation Act.

STATEMENT OF THE CASE

A. The Tortuous Path to Enactment of the Affordable Care Act

The Affordable Care Act is a 2,700-page collection of "sweeping and comprehensive" provisions, Pet. App. 20a, intended to impose "near-universal" health insurance coverage on the Nation. ACA § 1501(a)(2)(D). While it took Congress nearly a year to put together the massive health insurance overhaul that the President requested in early 2009, *see* 111 Cong. Rec. S11607-816 (daily ed. Nov. 19, 2009), the Senate passed the ACA a mere 35 days after it was introduced, and the Act became law only through unusual procedural machinations and by the barest of margins.

The slim majority of Senators who supported the Act succeeded in forcing it through on December 24, 2009, in the Senate's first Christmas Eve vote since 1895.[3] The process of reconciling the Senate bill and an earlier version passed by the House—and sending the reconciled bill back for passage in each—had barely begun when, in a special election on January 19, 2010, the people of Massachusetts elected Scott Brown, who had pledged to be "the 41st vote" in the Senate to "stop" the health care proposal from becoming law.[4] With further Senate action foreclosed, leaders in the House searched for a means of addressing their considerable reservations to the Senate-passed version of the law without necessitating an additional vote in the Senate. The leadership considered and rejected a number of remarkable proposals, including one that would have "deemed" a version enacted without an actual vote on the legislation.[5] Ultimately, they determined that the only course open to them was to vote on the Senate bill without the possibility of amendment, and address their reservations to the extent possible in later legislation on limited topics that would be procedurally privileged and exempt from the cloture rule in the Senate. *See* H.R. Res. 1203, 111th Cong. (Mar. 21, 2010). The unamended Senate bill passed the House by a narrow 219-212 vote, 111 Cong. Rec. H2153 (daily ed. Mar. 21, 2010), and the President signed the Patient Protection and Affordable Care Act into law on March 23, 2010.

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[3] Robert Pear, *Senate Passes Health Care Overhaul on Party-Line Vote*, N.Y. Times, Dec. 24, 2009, http://www.nytimes.com/2009/12/25/health/policy/25health.html.

[4] *Republican Scott Brown Vying for Kennedy Senate Seat*, http://www.foxnews.com/story/0,2933,582797,00.html; Gail Russell Chaddock, *Mr. Brown Goes to Washington, Signs His*

"Amendments" to that Act were made days later through a separate Health Care and Education Reconciliation Act of 2010 (HCERA), deemed a "reconciliation" bill to circumvent the now very real threat of a filibuster. As a result of that procedural maneuvering, that bill had to be limited to amendments that would have a direct budgetary

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Autograph "41", The Christian Science Monitor, Jan. 21, 2010, http://www.csmonitor.com/USA/Politics/2010/0121/Mr.-Brown-goes-to-Washington-signs-his-autograph-41.

[5] Lori Montgomery & Paul Kane, *House May Try to Pass Senate Health-Care Bill Without Voting On It*, Wash. Post, Mar. 16, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/03/15/AR2010031503742.html.

impact on the Act. 2 U.S.C. § 644. Like with the ACA's final passage, that act was presented under a no-amendments rule and made it through the House and Senate by a bare majority. *See* H.R. Res. 1225, 111th Cong. (Mar. 25, 2010).

B. The Substance of the Affordable Care Act

Together, the PPACA and the HCERA (collectively, the "ACA" or "Act") impose new and substantial obligations on every corner of society, from individuals to insurers to employers to States. Those obligations are designed to work in tandem to expand both the demand for and the supply of health insurance, so as to achieve Congress' ultimate goal of "near-universal coverage." ACA § 1501(a)(2)(D).

1. At the center of the ACA is a new mandate that commands nearly every individual to obtain and maintain a minimum level of health insurance coverage, thereby artificially increasing the demand for health insurance. ACA § 1501(b), 26 U.S.C.A. § 5000A(a). This mandate to maintain insurance applies to all individuals except foreign nationals residing here unlawfully, incarcerated individuals, and individuals falling within two very narrow religious exemptions. *Id.* § 5000A(d). A covered individual who fails to comply with the mandate is subject to a financial "penalty." *Id.* § 5000A(b)(1), (c). That penalty provision contains its own limited set of exemptions that differ from the exemptions set forth with respect to the mandate itself. *See id.* § 5000A(e). Thus, individuals fully subject to the mandate may be exempt from the penalty provisions designed to enforce the mandate. But exemption

from the penalty does not obviate such individuals' obligation to comply with the mandate. The two are separate. For example, while members of Indian tribes and certain low-income individuals are not subject to the penalty, *id.*, they are still subject to the mandate and must maintain a minimum level of health insurance coverage at all times.

The constitutionality of a mandate to maintain insurance was subject to serious question long before Congress enacted the ACA. When the concept first arose in the early 1990s, the Congressional Budget Office (CBO) informed Congress that "[a] mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action." CBO, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance* 1 (August 1994).[6] In the course of debate over the current legislation, the Congressional Research Service (CRS) advised that "[d]espite the breadth of powers that have been exercised under the Commerce Clause, it is unclear whether the clause would provide a solid constitutional foundation for legislation containing a requirement to have health insurance." CRS, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis* 3 (July 24, 2009).[7] CRS deemed that constitutional uncertainty "the most challenging question posed by such a proposal." *Id.*

In keeping with the constitutional concerns about a mandate to maintain insurance, the version of the Act that the House passed before the Senate passed the ACA included, along with a tax upon individuals who fail to obtain and maintain insurance, a severability clause instructing that, in the event any provision were held unconstitutional, the remainder of the Act should not be affected. *See* H.R. 3962, §§ 255, 501. The ACA that emerged from the Senate and was subsequently forced through the House, however, contained the individual mandate but no severability clause.

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[6] Available at http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf.

[7] Available at http://assets.opencrs.com/rpts/R40725_20090724.pdf.

Although numerous amendments were proposed during the ACA's drafting process to alleviate constitutional concerns by eliminating or limiting the reach of the mandate, each was defeated on the ground that doing so would make the Act's objective of near-universal insurance coverage unattainable. As one of the Act's principal architects put it, eliminating or limiting the mandate would "gut[] and kill[] health reform," as "[t]he effect [would be] to say no more ... universal coverage." *Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform of the S. Comm. on Finance*, 111th Cong. 21-22 (Oct. 1, 2009) (statement of Sen. Baucus); *see also Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform of the S. Comm. on Finance*, 111th Cong. 216 (Sept. 24, 2009) (statement of Sen. Baucus) (describing one such amendment as "a mortally wounding amendment" that would "undermine this whole system").[8]

2. The individual mandate addressed the demand side of the equation for near-universal coverage by requiring virtually every American to obtain health insurance. But Congress recognized that compliance with the mandate would not be possible for many individuals absent some set of additional provisions designed to increase the supply of insurance to meet the mandated increase in demand. Accordingly, Congress imposed four accompanying categories of insurance reforms, each of which targets a distinct segment of the then-uninsured population, so as to ensure that the Act would increase both the demand for *and* the supply of insurance, which, in turn, would bring the Nation closer to Congress' goal of near-universal coverage.

The first set of supply-side provisions is found principally in Subtitle C of Title I, which prohibits insurance practices that Congress concluded had prevented certain "high-risk" individuals from obtaining private insurance. Chief among those are the so-called "guaranteed issue" and "community rating" provisions, which require insurers to enroll every applicant for insurance and preclude insurers from denying, canceling, capping, or increasing the cost of coverage based on an individual's preexisting health conditions, medical history, or past experience with respect to insurance claims. ACA

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[8] Available at http://finance.senate.gov/hearings/hearing/?id=d7e5e3c3-eb4e-e366-c063-76040ad6da87; http://finance.senate.gov/hearings/hearing/?id=d8083e61-f98b-0204-3389-428e5a1a78e7.

§ 1201. Subtitle C and other sections of Title I also imposes numerous other requirements on insurers, including restrictions on how much they can charge for various plans and various services.

Congress predicted that those insurance market regulations would "have significant negative effects on the business costs of insurers because they require insurers to accept unhealthy entrants, raising insurers' costs." Pet. App. 178a; *see also* CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, 6 (Nov. 30, 2009) (predicting that insurance regulations without individual mandate would increase premiums by 27 to 30 percent).[9] Indeed, as Congress was aware, similar state-wide regulations enacted without an offsetting subsidy to insurers had caused insurers to exit the market.[10]

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[9] Available at http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf.

[10] *See, e.g.*, *Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health*, 111th Cong. 10 (Mar. 17, 2009) (Testimony, of Prof. Uwe Reinhardt) ("It is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance."), available at http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/031709_Health_Affordable_Coverage_Hearing/3.17.09_Reinhardt_Health_Affordable_Coverage.pdf; Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Politics, Pol'y & Law 71, 91–92 (2000) (documenting "dramatic exodus of indemnity insurers from New York's individual market" after similar regulations were enacted); *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the H. Comm. on Ways & Means*, 111th Cong. 117 (Apr. 22, 2009) (submission for the record of Phil

Accordingly, without any subsidy to help insurers cover those substantial new costs, the insurance industry would have had an obvious incentive to oppose those expensive new proposals, which, in turn, could have jeopardized the entire legislative effort.

The ACA's second set of supply-side provisions is found in Subtitles D and E of Title I. Subtitle D mandates the creation in each State of "health benefit exchanges," which will be run by either the State or the federal government. ACA §§ 1301–1343. Congress intended those exchanges to allow certain lower-income individuals and small businesses to pool their resources together to purchase private insurance plans comparable to plans purchased by larger employers. ACA § 1311. If a State is not willing to create and operate an exchange, the federal government will step in and do so itself. ACA § 1321(c). Subtitle E then establishes tax credits and other subsidies for the lower-income individuals and small businesses that purchase plans on the exchanges. ACA §§ 1401–21. Congress has estimated that getting these new exchanges up and running will cost at least $350 billion in federal spending by decade's end. Letter from Douglas Elmendorf, Director, CBO, to the Hon. Nancy Pelosi,

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Caper, M.D., and Joe Lendvai) (confirming same result in Maine), available at http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg52258/html/CHRG-111hhrg52258.htm.

Speaker, U.S. House of Reps. ("CBO Estimate"), Table 2 (Mar. 20, 2010).[11]

Third, Subtitle F of Title I contains a collection of "employer responsibility" provisions that Congress designed to force the expansion of employer-based insurance. ACA § 1511–15. Among other things, these provisions impose significant monetary penalties on any employer (including a State) with an average of at least 50 full-time equivalent employees that fails to provide all of those employees with a federally approved level of insurance coverage. ACA § 1513. The Act also offers tax incentives for small businesses that purchase health insurance plans for their employees. ACA § 1421.

Finally, whereas Congress designed the provisions found throughout Title I to expand the supply of private insurance, it designed Title II to force a comparable expansion of public insurance. Most prominently, Subtitle A effects a massive expansion of Medicaid by requiring all participating States (which is to say, all States) to offer Medicaid to all individuals under the age of 65 with incomes up to 133% of the poverty level, with a 5% "income disregard" provision that effectively raises that number to 138%. ACA §§ 2001, 2002(a). (Individuals who are 65 or older are eligible for Medicare.) In addition to providing coverage for these newly eligible individuals, States must also provide coverage for millions of individuals who are uninsured despite being currently eligible for

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[11] Available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

Medicaid, as those individuals will be forced onto the Medicaid rolls by the individual mandate. The CBO predicts that at least 16 million individuals will enroll in Medicaid as a result of the combined effect of the expansion and the mandate, and that the federal component of Medicaid spending will increase by $434 billion by 2020 to cover the costs generated by that massive increase in enrollment. CBO Estimate 9 & Table 4 (Mar. 20, 2010).

3. Congress' intentions as to the manner in which the ACA would function are best reflected in the findings accompanying the individual mandate. As those findings explain, Congress did not enact the mandate just to increase the demand for insurance in the abstract, and it did not enact the other core components just to increase the supply. Rather, Congress' paramount goal was "near-universal" health insurance coverage, ACA § 1501(a)(2)(D), something it believed could be achieved only if each of the Act's central provisions works in unison so that near-universal supply can meet the mandated near-universal demand.

In keeping with that understanding, the findings explain how Congress envisioned a comprehensive health insurance scheme in which the individual mandate would work "together with the other provisions of the Act [to] add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services," thereby "increas[ing] the number and share of Americans who are insured." ACA § 1501(a)(2)(C). The intended relationship among the various provisions is evident, for example, in Congress' finding that the mandate "build[s] upon and strengthen[s] the private employer-based health insurance system." ACA § 1501(a)(2)(D). Because employer-based insurance is one of the primary sources of coverage, Congress deemed the "employer responsibility" provisions necessary to ensure that employers would supply the insurance that individuals would be forced to maintain. The same understanding is evident with respect to the guaranteed issue and community ratings provisions, which Congress deemed key to ensuring that higher risk individuals who must purchase insurance will not be left uninsured by the privately financed market. *See* ACA § 1501(a)(2)(I).

Conversely, Congress also made explicit that it considered the individual mandate critical to the viability and success of the ACA's other core provisions. It did so most expressly with respect to the Act's insurance market regulations, deeming the mandate "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* In Congress' view, if insurance companies were forced to provide coverage to all applicants and cover pre-existing conditions, and "if there were no requirement [that currently healthy individuals purchase insurance], many individuals would wait to purchase health insurance until they needed care." *Id.* By forcing all individuals to purchase insurance regardless of their needs or desires, Congress expected the individual mandate to "minimize this adverse selection" that had doomed similar regulations in some States. *Id.*

Congress also explained that it intended the mandate to "broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums" by forcing into the market individuals unlikely to use the insurance they must purchase. *Id.* Congress considered that forced subsidization by individuals who might otherwise rationally choose not to purchase health insurance critical because, without it, the guaranteed issue, community rating, and other insurance market regulations would generate unmanageable new costs for insurers—and would have been strenuously opposed by the insurance industry. Indeed, the insurance industry made quite explicit its position that it would not support legislation that contained those regulations without an individual mandate. *See, e.g.*, Robert Pear, *Health Insurers Offer to Accept All Applicants, on Condition*, N.Y. Times, Nov. 20, 2008, at A30[12]; Br. of America's Health Insurance Plans in Partial Supp. of Cert. Review 15–19.

Congress also explained how it considered the mandate an "essential" component of its global regulatory scheme and overarching objective. According to Congress, "[b]y significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the [individual mandate], together with other provisions of th[e] Act, will significantly reduce administrative costs and lower health insurance premiums." ACA

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[12] Available at http://www.nytimes.com/2008/11/20/us/20health.html.

§ 1501(a)(2)(J). For those same reasons, Congress deemed inclusion of the mandate "essential to creating effective health insurance markets that do not require underwriting and eliminate its associated costs," *id.*, which Congress, in turn, considered essential to achieving its paramount goal of "near-universal" insurance coverage, ACA § 1501(a)(2)(D).

4. Many of the several hundred provisions found elsewhere in the ACA do not bear as obvious of a relationship to increasing the demand for or supply of health insurance. Upon closer analysis, however, those provisions also were designed to play an integral role in Congress' scheme for near-universal health insurance coverage and, equally importantly, in securing support for the Act. They achieve those ends by attempting either to "offset" the massive new spending generated by core provisions such as the Medicaid expansion and the exchanges, or to decrease the cost of the health care services that drive up the cost of insurance. Those cost-cutting measures were every bit as critical to the Act's passage as its provisions expanding the demand for and supply of insurance, as the President and key supporters of the Act emphatically refused to pass a bill that was not, at the very least, deficit neutral. *See, e.g.*, Letter from President Obama to Senators Kennedy and Baucus (June 3, 2009).[13] One day before the slim majority of the House passed the

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[13] Available at http://www.whitehouse.gov/the_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus.

ACA, the CBO provided a requested report to Congress estimating that the Act satisfied that condition, based in large part on cost savings and new revenue attributable to the provisions found throughout Titles III through IX. *See* CBO Estimate, Table 2 (Mar. 20, 2010).[14]

For example, Title III of the Act primarily consists of alterations to Medicare, a massive federally funded program that provides insurance to individuals who are over the age of 65 and therefore not subject to the individual mandate. *See* ACA § 1501(b). Title VI also makes changes to Medicare and other publicly funded programs in an effort to increase the effectiveness of the penalty and incentive systems designed to prevent provider and supplier fraud. While these provisions may not appear to bear a close relationship to increasing the demand for or supply of insurance, collectively, they were designed to achieve an estimated $455 billion in savings to counteract the $434 billion in costs generated by the Medicaid expansion and the $350 billion generated by the health benefit exchanges, both of which were critical components of Congress' scheme for near-universal insurance. CBO Estimate, Table 2 (Mar. 20, 2010).

The same cost-cutting intent is made manifest in the text of Title IX of the Act, which contains a subtitle expressly designated "Revenue Offset Provisions." As Congress' use of the term "offset" makes clear, the point of those penalties and taxes was not just to generate revenue, but to generate revenue for the specific purpose of counterbalancing the enormous costs of the Act's central provisions. As with the Medicare amendments, the CBO report estimated that these provisions would produce hundreds of billions of dollars in new revenue to offset the hundreds of billions of dollars in new spending on the exchanges and Medicaid. CBO Estimate, Table 2 (Mar. 20, 2010).

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[14] Title X of the Act is the HCERA, which primarily makes amendments to Titles I–IX.

Other sections of the Act reflect a more global effort to defray the underlying costs of medical care itself. For example, Title IV includes provisions aimed at increasing the availability and use of preventative services (particularly for those enrolled in publicly funded insurance programs) and promoting general wellness measures. Title V seeks to increase the supply of health care providers in an attempt to decrease the costs of the services they provide. And Title VII seeks to improve access to new medical therapies that Congress intended as cost-saving alternatives to current treatments. (Congress expressly instructed federal agencies to "determine the amount of savings to the Federal Government generated as a result of th[at] enactment" and to use any such savings "for deficit reduction." ACA § 7003.)

In context, these other sections of the ACA clearly are designed to decrease the cost of the health care services that drive up the cost of health insurance. By doing so, these sections play a key role in Congress' effort to make provisions such as guaranteed issue, community rating, and expanded employer-based insurance more palatable to insurers and employers who might otherwise oppose them, and to defray ongoing costs that the Medicaid expansion will generate. As a result, they are part and parcel of the Congress' supply-meets-demand vision of near-universal insurance coverage.

C. The Proceedings Below

Shortly after a bare majority of Congress enacted the ACA, Florida and 12 other States brought this action seeking a declaration that the Act is unconstitutional. They have since been joined by 13 additional States, the National Federation of Independent Business, and multiple individuals. The States argued that various aspects of the Act are unconstitutional, including the individual mandate and the Medicaid expansion. The States maintained that if those central provisions were struck down as unconstitutional, the entire Act must fall because the balance of the Act is not severable from the unconstitutional provisions at its heart.

The federal government defended the challenged provisions of the Act as constitutional and repeatedly emphasized the centrality of the individual mandate in achieving Congress' broader goals. The federal government stressed that Congress considered the Act's core provisions "interrelated," Mem. Supp. Govt.'s Mot. Dismiss 3 [R.E. 98], and considered the mandate "necessary to make the other regulations in the Act effective." Mem. Supp. Govt.'s Mot. Dismiss 48 [R.E. 143]; *see also* Mem. Supp. Govt.'s Mot. Summ. J. 16 [R.E. 999] (describing mandate as "an integral part of the ACA's larger reforms of health insurance industry practices").

The federal government explained Congress' view that many of the "individuals whose conduct is regulated by the minimum coverage provision ... affirmatively seek insurance but are unable to obtain it without the insurance market reforms, tax credits, cost-sharing, and Medicaid eligibility expansion that the Act will provide." Mem. Supp. Govt.'s Mot. Summ. J. 1–2 [R.E. 984–85]. Accordingly, Congress envisioned the mandate "work[ing] in tandem with these and other reforms" to increase *both* supply *and* demand, thereby furthering Congress' ultimate goal of near-universal insurance coverage. Mem. Supp. Govt.'s Mot. Dismiss 46 [R.E. 141]; *see also* Mem. Supp. Govt.'s Mot. Dismiss 3 [R.E. 98] (arguing that insurance market regulations "make health insurance more available," while exchanges, tax credits, and Medicaid expansion "make insurance more affordable"). Based on that integrated relationship, and the reality that the insurance industry would not have supported the Act without the individual mandate, the federal government expressly conceded that, at a minimum, the Act's insurance market regulations are inextricably linked to the mandate, such that Congress would not have intended either to survive without the other. Mem. Supp. Govt.'s Mot. Dismiss 46–48 [R.E. 141–43].

The federal government also explained the intended integral relationship between the Act's less prominent pieces and its core components. The federal government argued that "[w]hen Congress passed the ACA, it was careful to ensure that any increased spending, including on Medicaid, was offset by other revenue-raising and cost-saving provisions." Mem. Supp. Govt.'s Mot. Summ. J. 41

[R.E. 1024]. The federal government made similar arguments as to how central provisions were designed to offset each other—for example, it argued that Congress assumed insurance market regulation would create significant savings for States when it deemed it appropriate to force cash-strapped States to pay $20 billion to cover the Medicaid expansion. Mem. Supp. Govt.'s Mot. Summ. J. 41 [R.E. 1024].

1. The District Court's Decision

The District Court agreed with the States that the individual mandate is unconstitutional. Pet. App. 350a. Although the court rejected the States' challenges to the Medicaid expansion and other provisions of the ACA, the court also agreed with the States that the mandate cannot be severed from the rest of the Act and therefore declared the entire ACA invalid. Pet. App. 363a.

In its severability analysis, the court first noted the federal government's concession that "the individual mandate and the Act's health insurance reforms, including the guaranteed issue and community rating, will rise or fall together." Pet. App. 350a. That, in turn, led the court to conclude that "the only question is whether the Act's other, non-health-insurance-related provisions can stand independently." Pet. App. 350a. Although the court acknowledged the presumption in favor of severability, it noted that "this is anything but the typical case." Pet. App. 351a. As the court put it, "[i]f ... the statute is viewed as a carefully-balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal, and if that goal would be undermined if a central part of the legislation is found to be unconstitutional, then severability is not appropriate." Pet. App. 352a. Examining the statute and the context in which it was passed, the court found that the ACA fits that description.

In doing so, the court observed that "some (perhaps even most) of the remaining provisions can stand alone and function independently of the individual mandate," Pet. App. 352a, but recognized that "the 'more relevant inquiry' is whether these provisions will comprise a statute that will function 'in a *manner* consistent with the intent of Congress.'" Pet. App. 353a (quoting *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987)). As to that inquiry, the court noted that a severability clause "had been included in an earlier version of the Act, but ... was removed in the bill that subsequently became law," which the court found significant given that "Congress was undoubtedly well aware that legal challenges [to the mandate] were coming." Pet. App. 355a. The court also found the federal government's concession that the Act's insurance provisions must fall with the mandate "extremely significant because the various insurance provisions, in turn, are the very heart of the Act itself." Pet. App. 356a. "In other words, the individual mandate is indisputably necessary to the Act's insurance market reforms, which are, in turn, indisputably necessary to the purpose of the Act." Pet. App. 359a.

In light of those findings, the court concluded that "[s]evering the individual mandate from the Act along with the other insurance reform provisions ... cannot be done consistent with the principles set out" in this Court's cases. Pet. App. 361a. The court explained that any attempt to rescue some hodgepodge of independently functional provisions would "be tantamount to rewriting a statute in an attempt to salvage it." Pet. App. 361a. The court therefore declared the Act invalid it its entirety.

2. The Eleventh Circuit's Decision

The Eleventh Circuit affirmed the District Court's holding that the individual mandate is unconstitutional but reached precisely the opposite conclusion as the District Court did when it came to severability: It deemed the mandate completely severable and left the entirety of the Act except the mandate standing. Pet. App. 186a.

As to the bulk of the Act, the Eleventh Circuit found it sufficient that "[e]xcising the individual mandate ... does not prevent the remaining provisions from being 'fully operative as a law.'" Pet. App. 174a (quoting *Brock*, 480 U.S. at 684). In the court's view, the mandate could be severed from all provisions of a "stand-alone nature" that "lack [a] connection to the individual mandate." Pet. App. 176a. As to the District Court's finding that Congress did not intend those provisions to stand without the mandate, the court maintained that the District Court "placed undue emphasis on the Act's lack of a severability clause," and that Congress' removal of the earlier severability clause should have "no probative impact." Pet. App. 175a–76a. The court then suggested that the lack of a *non*-severability clause makes the States' "burden" of establishing non-severability particularly "heavy." Pet. App. 176a.

The court next turned to the guaranteed issue and community rating provisions, as to which the court characterized the severability inquiry as "not so summarily answered." Pet. App. 176a. The court acknowledged Congress' express finding that the individual mandate is "essential" to those provisions, Pet. App. 177a, and Congress' evident intent that the mandate "mitigate the reforms' cost on insurers by requiring the healthy to buy insurance and pay premiums to insurers to subsidize the insurers' costs in covering the unhealthy." Pet. App. 178a. But the court again suggested that "Congress could easily have included in the Act a non-severability clause" if it intended those provisions to fall with the mandate, and noted that "none of the insurance reforms ... contain[s] any cross-reference to the individual mandate or make[s] their implementation dependent on the mandate's continued existence." Pet. App. 179a. The court further concluded that "a basic objective of the Act is to make health insurance coverage accessible," and that, "[a]ll other things being equal, ... a version of the Act that contains these two reforms would hew more closely to Congress's likely intent than one that lacks them." Pet. App. 180a.

The court then proceeded to engage in its own analysis of whether the mandate is, in fact, essential to the two insurance market regulations. According to the court, "many other provisions," including the exchanges and the employer regulations, "help to accomplish some of the same objectives as the individual mandate." Pet. App. 181a. And the court found it relevant that the "mandate has a comparatively limited field of operation vis-à-vis the number of uninsured" given its exemptions and the limited means of enforcing its penalty provision. Pet. App. 182a. According to the court, these "multiple features ... all serve to weaken the mandate's practical influence on the two insurance product reforms." Pet. App. 183a.

While the court recognized that it must be "[m]indful" of Congress' express findings to the contrary, it nonetheless deemed those findings "not particularly relevant" because they arose in the context of Congress' Commerce Clause authority. Pet. App. 184a. The court further maintained that "[t]he fact that one provision may have an impact on another provision is not enough to warrant the inference that the provisions are inseverable," and found that "particularly true here because the reforms of health insurance help consumers who need it the most." Pet. App. 185a.

"In light of all th[o]se factors," the court found itself "not persuaded that it is *evident* (as opposed to possible or reasonable) that Congress would not have enacted the two reforms in the absence of the individual mandate." Pet. App 185a. Although the court acknowledged the federal government's express concession to the contrary, it deemed that concession irrelevant, observing that "the touchstone of severability analysis is legislative intent, not arguments made during litigation." Pet. App. 186a n.144. The court therefore severed the individual mandate and left the rest of the ACA standing.

SUMMARY OF ARGUMENT

Severability is a remedial inquiry that turns on legislative intent. The ultimate question is not whether the balance of an act can function independently without an invalidated provision. That is a necessary, but not sufficient, condition for preserving the balance of the statute. The ultimate question is whether Congress would have enacted the statute without the invalidated provision. Here, the answer is clear. Congress considered the individual mandate essential to the Act's functioning, to its passage, and to its ability to achieve Congress' goal of near-universal health insurance. This Court cannot remove the hub of the individual mandate while leaving the spokes in place without violating Congress' evident intent.

Precisely because severability is a remedial inquiry, the federal government is wrong to suggest that this Court can address severability only as to the provisions of the Act that independently burden the States. Non-severability is not an independent basis for challenging discrete components of a statute. Rather, severability is an inquiry into the remedial consequences for the rest of a statute of invalidating a successfully challenged provision. If this Court strikes down the individual mandate as unconstitutional, it must also consider the remedial consequences of that decision for the balance of the Act, without regard to whether the rest of the Act independently burdens the States or other plaintiffs. There is no obstacle to the Court fully considering the severability question.

The severability question is always one of legislative intent, and discerning that intent is often difficult because it requires a counterfactual inquiry into whether Congress would have passed a statute without a provision it intentionally included. But here Congress made the essential role of the individual mandate and its relationship to the other key provisions of the ACA manifest in its legislative findings. What is more, as a practical matter, it is clear that every provision of the ACA was critical to its passage. Not only did Congress consider the individual mandate central to the Act and necessary to make the other provisions work as intended; it considered the mandate a critical means of achieving its overall goal of providing near-universal health insurance. Congress enacted the individual mandate to ensure that there would be near-universal demand and enacted a series of costly provisions—insurance market regulations, exchanges, employer regulations, and Medicaid expansion—to ensure that there would be near-universal supply. But Congress did not pursue either supply or demand for its own sake. If this Court invalidates the demand side, there is no basis for leaving the supply side standing.

Even the federal government recognizes that the individual mandate cannot be decoupled from the Act's guaranteed issue and community rating provisions. Quite simply, the guaranteed issue and community rating provisions would not have been enacted without the individual mandate. As a policy matter, Congress was told that States that had enacted those regulations without mandating individual coverage drove insurers from the State and insureds out of the market by dramatically increasing the cost of insurance. And as a practical matter, the insurance companies would have resisted those costly requirements without the subsidization created by a mandate that forces healthy individuals into the insurance market.

But while the federal government acknowledges that the guaranteed issue and community rating provisions must fall with the individual mandate, it ignores the consequences for the rest of the Act. If the individual mandate is the key to how the Act was to function, the guaranteed issue and community rating provisions were the key impetus for getting the Act passed. Without the promise of insuring the uninsured, there is no prospect that the ACA ever would have become law.

While some of the remaining provisions of the ACA do not bear the same direct demand-supply relationship as the individual mandate and the supply-side provisions, they too cannot survive the invalidation of the Act's core components. Many of those provisions were designed to offset the costs of the expensive supply-side provisions necessitated by Congress' goal of near-universal insurance. Indeed, Congress expressly labeled some of those provisions "offsets." The massive expansion of Medicaid was a costly endeavor that Congress attempted to counterbalance with projected cost savings. If the Medicaid expansion is invalidated directly or falls as a consequence of invalidation of the individual mandate, then these offsetting provisions cannot survive while respecting Congress' intent.

The Court of Appeals erred by giving only summary treatment to most of the Act and then substituting its own view for Congress' when it came to the guaranteed issue and community rating provisions. It also focused unduly on the absence of a non-severability clause while giving no weight to the removal of a severability clause during the legislative process. Ultimately, however, the key to

Congress' intent is not the absence or presence of a clause specifically addressing severability. Congress made its intent clear when it identified the individual mandate as an essential provision addressing the demand side of its goal of providing near-universal coverage. To invalidate that central provision while leaving in place provisions designed to supply the forced demand created by the individual mandate would ignore both this Court's severability precedents and Congress' evident intent.

ARGUMENT

I. Severability Is A Remedial Inquiry That Is Properly Before This Court.

There is no obstacle to this Court considering the issue of severability and the remedial consequences for the balance of the Act if the Court invalidates certain provisions of the ACA. While the federal government has suggested that the Court may not consider severability unless the States "demonstrate that each of the Act's provisions they contend is inseverable ... 'burden[s]' them," Govt.'s Response Pet. Cert. 29 (quoting *Printz v. United States*, 521 U.S. 898, 935 (1997)), that argument reflects a fundamental misunderstanding of the nature of the severability inquiry. Severability does not involve a distinct challenge to the remaining provisions of an act that must be supported by independent standing. Instead, severability considers the consequences for the balance of the statute of the invalidation of provisions that the challenger has already successfully attacked.

Severability is a *remedial* doctrine. *See Ayotte v. Planned Parenthood of Northern New England*, 546

U.S. 320, 328–29 (2006). It becomes relevant only when a court has struck down a provision of a broader statute or statutory scheme, and its purpose is to allow courts to give effect to "what 'Congress would have intended'" had it known that a piece of broader legislation would be invalidated. *United States v. Booker*, 543 U.S. 220, 246 (2005) (quoting *Denver Area Ed. Telecomm. Consortium, Inc. v. FCC*, 518 U.S. 727, 767 (1996)).

The ultimate touchstone of this remedial inquiry is the legislature's intent. *See Brock*, 480 U.S. at 683 n.5 (severability is "a question of legislative intent"). Just as courts should use their remedial power to avoid invalidating more of an act than necessary when doing so would be contrary to Congress' intent, courts should use their remedial power to avoid leaving the remnants of an act in place when "it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not." *Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932). To do so "would be to substitute, for the law intended by the legislature, one they may never have been willing, by itself, to enact." *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 636 (1895) (internal quotation marks omitted).

As the very nature of the inquiry reflects, severability is a shield for the legislature, not a sword for the challenging party. It is the Court's obligation to craft a suitable remedy that reflects Congress' intent, not the challenger's independent right to particular relief, that gives rise to the severability inquiry. *See, e.g., Ayotte*, 546 U.S. at 330 ("After finding an application or portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all?"); *New York v. United States*, 505 U.S. 144, 186 (1992) ("Having determined that the take title provision exceeds the powers of Congress, we must consider whether it is severable from the rest of the Act.").

Whether the party contending that the balance of the statute does not survive the invalidation of the provision it has successfully challenged (and, *a fortiori*, had standing to challenge) has independent standing to challenge the balance of the act is thus irrelevant. That party is not bringing a separate "non-severability" claim to the balance of the statute, but is merely assisting the Court in ascertaining what remedial consequences flow from the invalidation of the provision successfully challenged, *i.e.*, what remedy will adhere most closely to the legislature's intent. That the parties may have an interest in one outcome or another does not change that basic fact.[15]

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[15] Indeed, in some cases, the party that has successfully challenged one provision will have an affirmative interest in arguing that other provisions of the statute are severable and survive in order to obtain the most advantageous remedy. *See, e.g.*, *INS v. Chadha*, 462 U.S. 919, 934 (1982). In other cases, a party's right to effective relief may depend on prevailing on the principal challenge *and* on the severability analysis that follows. *See, e.g.*, *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010); *Brock*, 480 U.S. at 684. In either case, the severability analysis is a distinct remedial question.

The federal government's attempt to insert a separate standing requirement into the severability analysis therefore would frustrate the remedial powers of the courts, as it would preclude courts from employing appropriate measures to ensure that their decisions do not "substitute the judicial for the legislative department of the government." *United States v. Reese*, 92 U.S. 214, 221 (1875). That point is evident from the federal government's arguments in this case. For example, by the federal government's own telling, Congress would not have enacted the guaranteed issue and community rating provisions had it known the individual mandate would be held unconstitutional. Yet the federal government insists the Court *must* leave those provisions in place if it invalidates the mandate because, "even when particular provisions are integrally related, a court may not address provisions that do not burden parties to the litigation." Govt.'s 11th Cir. Br. 59. By the federal government's reasoning, that would seem to be the case even if the ACA contained an express *non*-severability provision directing that those provisions should stand or fall with the individual mandate. Even such an unmistakable indication of congressional intent could not make up for the lack of independent standing to challenge the balance of the statute that the federal government would erroneously demand.

Nothing in this Court's precedent compels that illogical result. The federal government attempts to ground its novel argument in the Court's decision in *Printz*. But *Printz* did not adopt the extreme position that the federal government advocates. The

Court in *Printz* merely declined to consider an argument that discrete provisions of an act were non-severable when severability had not been raised in the petition for certiorari, had not been addressed by the court of appeals, and would not have had *any* effect on the parties before the Court. *See Printz*, 521 U.S. at 935. In doing so, the Court did not hold that it was without remedial power to fashion an appropriate remedy, but rather simply "decline[d] to speculate" on the severability inquiry in the absence of a party with an interest in the particular provisions subject to dispute. *Id.*

Printz may reflect nothing more than the unremarkable proposition that courts will not "speculate" concerning issues that have not been fully developed at each stage of the litigation. *See, e.g., Legal Servs. Corp. v. Valazquez*, 531 U.S. 533, 549 (2001) (exercising Court's "discretion and prudential judgment" to decline to reach severability question that was not briefed); *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 553 (2001) (declining to consider severability when it was not addressed below). At most, *Printz* might be read to suggest a prudential rule of restraint when the party asserting non-severability has *no* stake in whether the remainder of the legislation stands or falls. *Cf. New York*, 505 U.S. at 186–87 (addressing severability where remaining provisions affected plaintiffs). But any such rule would have no application in this case. As the federal government concedes, the States are affected, at a minimum, by the ACA's extensive amendments to Medicaid and its various employer regulations. *See* Govt.'s Response Pet. Cert. 30. That is more than sufficient to supply any requisite interest in whether the individual mandate is severable from the remainder of the Act.

The federal government appears to read *Printz* as demanding much more and confining this Court's inquiry to whether the specific provisions that independently burden the States survive. But neither *Printz* nor anything else limits the Court's remedial role in that way. The point of the severability inquiry is to determine whether Congress "would … have been satisfied with what remains" after the invalid portion of the statute is removed. *Williams v. Standard Oil Co.*, 278 U.S. 235, 242 (1929). It would be entirely artificial for courts to engage in that analysis by examining in isolation the relationship between the invalid provision and the remaining provisions that burden the challenger, rather than the relationship between the invalid provision and the broader legislative effort of which it was a part. *See, e.g.*, *Brock*, 480 U.S. at 685 (examining "the importance of the [invalid provision] in the original legislative bargain"); *INS v. Chadha*, 462 U.S. 919, 934 (1982) (invalid provision "cannot be considered in isolation but must be viewed in the context of Congress'" broader legislative goals).

The artificial inquiry the federal government urges also would produce wholly unworkable results. That much is clear from how the federal government would have the Court resolve this case. The States' argument is not just that the individual mandate was central to Congress' decision to enact *the employer regulations*, but that it was central to Congress' decision to enact *the ACA*. Yet the federal government would require the Court to leave every other provision of the ACA in place even if it *agreed* with the States that Congress "would not have enacted those provisions which are within its power, independently of" the individual mandate. *Champlin Ref.*, 286 U.S. at 234.

Nor is it clear how the federal government envisions Congress' intent being vindicated even in subsequent cases. Presumably, if the severability inquiry in the case that invalidates part of a statute on constitutional grounds were limited to other provisions that independently burdened the party bringing the successful constitutional challenge, the validity of the balance of the statute would need to await a party independently burdened by those other provisions. But it is not at all clear what claim such a party would bring. There is no independent cause of action for non-severability or interference with congressional intent. The reality is that those other provisions fall, if at all, not because of an independent defect that must be supported by independent standing, but as a remedial consequence of the earlier action.

To take the insurance market provisions as an example, insurance companies certainly have standing to challenge the guaranteed issue and community rating provisions, but they have little incentive to challenge the individual mandate. Indeed, the individual mandate's requirement that healthy individuals join the risk pool to the benefit of insurers was the key to eliminating the insurance industry's natural incentive to block legislation (whether through lobbying or litigation) that imposed massive new costs on the industry. And the fact that the mandate was the sweet that caused the insurance industry to accept the bitter market regulations is both the reason the insurance industry would not challenge the mandate's constitutionality and the reason the provisions stand or fall together. But if the failure of insurers to join the challenge to the individual mandate means this Court cannot consider the severability of the guaranteed issue and community rating provisions, it is unclear how that question can ever be considered. Without the sweet of the individual mandate, insurers would have every incentive to challenge the guaranteed issue and community rating provisions, but it is not clear what cause of action they could bring.

Those practical problems reveal the basic flaw in the federal government's reasoning. The argument that the individual mandate is not severable from the remainder of the ACA is not a series of discrete challenges to each of the Act's hundreds of remaining provisions. It is an argument about which *remedy* would do the least damage to Congress' intent if the States' challenge *to the individual mandate* (and/or their challenge to the Medicaid expansion) succeeds. Any standing questions that might arise if the States were raising separate challenges to separate provisions of the ACA are irrelevant to that remedial inquiry. If it is evident that Congress did not intend the ACA to survive without its unconstitutional provisions, then this Court can and should use its remedial power to give effect to that intent *in this case*, rather than leaving in place a fragmented version of legislation that Congress would "never have been willing, by itself, to enact." *Pollock*, 158 U.S. at 636.

II. The ACA Is A Delicate Balance Of Inextricably Intertwined Provisions, None Of Which Can Survive Without The Act's Core Components.

As noted, severability analysis is, at its core, an inquiry into legislative intent. A proper application of the correct severability analysis reveals that the individual mandate not only was central to "the original legislative bargain" that produced the ACA, *Brock*, 480 U.S. at 685, but also was deliberately designed to work as an essential complement to the Act's other core provisions to achieve Congress' overarching objective of near-universal insurance coverage. Congress' goal was neither to increase demand for insurance in the abstract nor to increase supply for its own sake. Instead, Congress sought to ensure an adequate supply to meet the artificial demand forcibly created by the individual mandate, all in service of the ultimate goal of supply and demand meeting at the point of near-universal coverage. Without the constitutionally invalid individual mandate, Congress would not have enacted the provisions designed to ensure a supply adequate to meet the demand created by the mandate or the cost-savings provisions designed to counterbalance the expensive supply-side provisions. Accordingly, this truly is a case in which "it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not." *Champlin Ref.*, 286 U.S. at 234. The Court should therefore hold the ACA invalid in its entirety.

A. The Touchstone of Severability Analysis Is Legislative Intent.

As is clear from the conflicting decisions addressing the severability of the individual mandate, the contours of the severability inquiry are a source of confusion among lower courts. Indeed, four different courts, all purporting to apply the same "well established" severability standard, *Brock*, 480 U.S. at 684, have reached four different conclusions as to whether and how the individual mandate should be severed from the rest of the ACA. *See Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 790 (E.D. Va. 2010) (holding mandate non-severable from only "directly-dependent provisions"); Pet. App. 363a–64a (holding mandate non-severable from entire Act); Pet. App. 186a (holding mandate severable from entire Act); *Goudy-Bachman v. U.S. Dep't of Health and Human Servs.*, —— F. Supp. 2d ——, No. 1:10-CV-763, 2011 WL 4072875 (M.D. Penn. Sept. 13, 2011) (holding mandate non-severable from only guaranteed issue and community rating provisions). The Court should take this opportunity to clarify the relevant legal principles and, in particular, the primacy of legislative intent. This is a case where Congress made the co-dependence of the various provisions evident in the text of the statute itself. Nonetheless, the Court of Appeals below lost sight of that critical indicator of legislative intent and instead essentially imposed a "non-severability" clause requirement that finds no support in this Court's precedents.

"[T]he touchstone for any decision about remedy is legislative intent, for a court cannot 'use its remedial powers to circumvent the intent of the legislature.'" *Ayotte*, 546 U.S. at 330 (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979) (Powell, J., concurring in part and dissenting in part)). Accordingly, the ultimate question in a severability inquiry is whether "it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not." *Champlin Ref.*, 286 U.S. at 234. While courts do not lightly strike down any statute, the standard is "evident" legislative intent, not a clear statement test, or whether the balance can operate independently, or whether there are cross-references, let alone a rule that the balance of a statute always survives absent a non-severability clause. If the legislature still would have enacted the remainder, then "the invalid part may be dropped if what is left is fully operative as a law." *Id.* But if a court arrives at the conclusion that the legislation would not have been enacted without the invalid provision, the court must give effect to Congress' evident intent and hold the legislation invalid in its entirety. *Id.*

As that "well established" severability test makes clear, *Brock*, 480 U.S. at 684, there is a critical difference between whether an act *can* stand and whether an act *should* stand without an invalid provision. That distinction is made manifest in this Court's decision in *Brock*. *Brock* involved an inquiry into the severability of a legislative veto, a provision "which by its very nature is separate from the operation of the substantive provisions of a statute." *Id.* If the only requirement for severability were the capacity for independent operation, then *Brock* could have ended its severability analysis with that single observation. But this Court did not end its analysis there, and instead reiterated that "[t]he more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress." *Id.* at 685.[16]

To be sure, "Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently." *Id.* at 684; *see also Hill v. Wallace*, 259 U.S. 44, 70 (1922) ("'We are not able to reject a part which is unconstitutional and retain the remainder, because it is not possible to separate that which is unconstitutional, if there be any such, from that which is not.'" (quoting *Trade-Mark Cases*, 100 U.S. 82, 98–99 (1879))). But while the capacity for independent functionality is a necessary condition for severability, it is by no means sufficient. "[E]ven in a case where legal provisions may be severed from those which are illegal," a court may sever "only where it is plain that Congress would have enacted the legislation with the unconstitutional provisions eliminated." *Employers' Liability Cases* (*Howard v. Ill. Cent. R.R. Co.*), 207 U.S. 463, 501 (1908).

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[16] In that respect, severability analysis differs from constitutional analysis and inquiry under the Necessary and Proper Clause. Whereas severability focuses solely on Congress' motivations and intentions, constitutional analysis often encompasses consideration of whether legislative provisions *in fact* serve the purposes Congress claims they were intended to serve. *See, e.g.*, *United States v. Lopez*, 514 U.S. 549, 567 (1995); *United States v. Comstock*, 130 S. Ct. 1949, 1966–67 (2010) (Kennedy, J., concurring). That Congress considers one legislative provision "necessary" to another does not make it so.

Nor is it sufficient that "Congress would have enacted *some* form of" legislation on the same subject matter even without the invalid provision. *Brock*, 480 U.S. at 685 n.7. "Any such inquiry, of course, would be tautological, as Congress' intent to enact a statute on the subject is apparent from the existence of" the legislation at hand. *Id.* The inquiry instead must focus on whether "the statute created in [the] absence [of the invalid provision] is legislation that Congress would not have enacted." *Id.* at 685. If so, to retain that legislation "would be to substitute for the law intended by the legislature one they may never have been willing, by itself, to enact." *Pollock*, 158 U.S. at 636.

That concern is nowhere more relevant than in a case like the present one, where the Act in question was the product of a divisive legislative process in which proponents of the bill consciously decided that changing *any* aspect of the Senate bill would endanger the entire enterprise. To deem it sufficient that Congress would have passed some form of health insurance legislation would be to turn a blind eye to the actual process that produced the ACA, and the unique circumstances calling into serious question whether Congress would have passed health insurance legislation at all if even a single word of the ACA was altered, let alone if there were no individual mandate to secure the critical support of the insurance industry. In fact, the procedural wrangling that produced the ACA was such that the House leadership decided that adding or removing *anything* from the Senate bill the House viewed as suboptimal would preclude passage of the Act. *See supra*, pp. 2–4. This case thus vividly illustrates that any meaningful inquiry into legislative intent cannot be satisfied by mere generalizations about legislative interest in broad subject matter areas, but instead must involve careful consideration of the particular legislation at hand and the unique circumstances under which it was enacted.

As with any inquiry into legislative intent, the severability analysis of course begins with the text of the statute. "The inquiry is eased when Congress has explicitly provided for severance by including a severability clause in the statute" or has included a non-severability clause. *Brock*, 480 U.S. at 686. But when Congress does not include such a clause, "Congress' silence is just that." *Id.* And even a severability clause can be overcome by convincing evidence to the contrary, such as the absence of any feasible means of separating the valid from the invalid. *See Hill*, 259 U.S. at 70 (deeming invalid provision "so interwoven with [other] regulations that they cannot be separated," even though Congress included severability clause); *cf. Elec. Bond & Share Co. v. SEC*, 303 U.S. 419, 435 (1938) (engaging in detailed analysis of other evidence of legislative intent despite presence of severability clause). Thus, while a severability clause is certainly relevant, "the ultimate determination of severability will rarely turn on the presence or absence of such a clause." *United States v. Jackson*, 390 U.S. 570, 586 n.27 (1968). Moreover, the presence or absence of a severability clause is not the only means by which Congress can address severability in the text of the statute. In a case like this one, where Congress expressly addressed the intended interrelationship of various provisions in findings included in the enacted text, such findings directly inform the severability analysis.

In the end, while there are objective criteria that in some instances can make the severability inquiry an easy one, the inquiry by its nature is often more complex. That is because the basic goal is to determine whether "the purpose of the Act is ... defeated by the invalidation of the [challenged] provision." *New York*, 505 U.S. at 187; *see also Free Enter. Fund*, 130 S. Ct. at 3162 (asking whether Congress "would have preferred no Board at all to a Board whose members are removable at will"); *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (plurality opinion) (asking whether "the policies Congress sought to advance ... can be effectuated even though [the invalid provision] is unenforceable"); *R.R. Ret. Bd. v. Alton R.R. Co.*, 295 U.S. 330, 362 (1935) (asking whether invalid parts "so affect[ed] the dominant aim of the whole statute as to carry it down with them"). Because even when Congress anticipates constitutional challenges, it rarely directly addresses a scenario of partial invalidation, courts often cannot answer that "elusive inquiry," *Chadha*, 462 U.S. at 932, without considering a broad spectrum of indicia of legislative intent, including "the importance of the [invalid provision] in the original legislative bargain," *Brock*, 480 U.S. at 685, and "the historical context" in which legislation was enacted, *Free Enter. Fund*, 130 S. Ct. at 3162; *see also Chadha*, 462 U.S. at 934.

Taking all of that evidence into account, a court's ultimate duty is to answer the remedial question of what "Congress would have intended in light of the Court's constitutional holding." *Booker*, 543 U.S. at 246. If "it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not," *Champlin Ref.*, 286 U.S. at 234, then the reviewing court has an obligation not to leave the balance of the legislation in place.

B. The ACA's Core Components Cannot Survive Without the Individual Mandate.

Applying these core precepts, the answer to the severability question here is clear: The ACA cannot stand without the individual mandate. Congress itself declared the individual mandate a core component of the ACA and identified its intended interrelationship with the other central provisions of the Act. Congress did not address either the demand or the supply side of the insurance equation for its own sake, but instead sought to ensure that supply would be sufficient to meet the demand created by the individual mandate, in service of a goal of near-universal coverage. Without the demand mandated by the individual mandate, Congress would not have enacted the various supply-side provisions. And without those core components, Congress would not have enacted the Act. As the District Court found, the ACA is akin to "a finely crafted watch." Pet. App. 362a. Its pieces "all work toward one primary legislative goal ... that ... would be undermined if a central part of the legislation is found to be unconstitutional." Pet. App. 352a. Because at least "one essential piece (the individual mandate) is defective and must be removed," Pet. App. 362a, the Act cannot function in the manner that Congress intended. Accordingly, the Court should give effect to Congress' evident intent and hold the ACA invalid in its entirety.

1. The ACA's core provisions are carefully constructed to work in unison to achieve Congress' paramount goal of "near-universal" insurance coverage. ACA § 1501(a)(2)(D). In determining how to obtain that objective, Congress perceived two basic barriers: Not everyone who wants insurance can get it, and not everyone who can get insurance wants it. Because addressing either in isolation would not solve—and, indeed, could exacerbate—the problem, Congress crafted a two-pronged attack of increasing both supply *and* demand to achieve near-universal coverage. On the demand side, Congress enacted the individual mandate to force individuals who do not want insurance to obtain it, even if (indeed, especially if) they are unlikely to need it. That, in turn, would make it more affordable for insurers to provide insurance to higher risk and lower income individuals. On the supply side, Congress enacted a series of measures—insurance market regulations, exchanges and subsidies, employer regulations, and expanded Medicaid—designed to force an increase in the supply of private, employer-based, and public insurance. That, in turn, would guarantee that everyone—including individuals previously unable to obtain it and individuals forced into the market by the mandate—would have a ready supply of insurance available.

Because Congress was not seeking to deal with perceived supply-side defects (those who want insurance but cannot get it) or perceived demand-side problems (those who can get insurance but do not want it) in isolation, the ACA can only operate in the manner that Congress intended—a manner that achieves near-*universal* insurance coverage—if both sides of the equation are intact. In Congress' view, without the artificially increased demand that the individual mandate creates in general, and the forced subsidization created by the mandate's effect on healthy individuals in particular, the Act's corresponding increase in supply would be potentially unnecessary and in all events unaffordable. Without the forced subsidization worked by the mandate, the insurance companies could not comply with the mandate to insure higher risk individuals without dramatically driving up costs and potentially exacerbating the problem. And without the mandated increase in supply, universal compliance with the individual mandate would be unattainable because forced demand would outstrip voluntary supply. Thus, once any of the Act's core supply and demand provisions is removed, it ceases to be an act designed to achieve near-universal health insurance coverage, let alone an act designed to achieve it in the manner Congress envisioned.

In keeping with that understanding of the ACA's animating logic, both Congress and the federal government have repeatedly emphasized that *all* of the Act's central provisions were designed to "work in tandem" to further Congress' basic goal of near-universal insurance coverage. Pet. App. 358a; *see also* Pet. App. 185 n.142 ("Congress itself states that *all* the provisions of the Act operate together to achieve its goals"). As the federal government put it, in Congress' estimation, many of the "individuals whose conduct is regulated by the minimum coverage provision ... affirmatively seek insurance but are unable to obtain it without the insurance market reforms, tax credits, cost-sharing, and Medicaid eligibility expansion that the Act will provide." Govt.'s Mem. Support Summ. J. 1–2 [R.E. 984–85]. That is why Congress considered the mandate alone insufficient to expand the number of insured, and deemed it necessary to identify and remedy whatever deficiencies Congress perceived in the availability of insurance in each discrete segment of the uninsured population. Only by working "together with the other provisions of th[e] Act" did Congress believe the mandate could further its overarching goal of "increas[ing] the number and share of Americans who are insured." ACA § 1501(a)(2)(C).

That is not to suggest that Congress considered the mandate less critical than the provisions mandating an increase in the supply of insurance. Quite the contrary, Congress explicitly and repeatedly deemed the mandate "essential" to the entire regulatory scheme it endeavored to create, both in terms of the universality and the affordability of insurance. *See* ACA § 1501(a)(2)(H) ("The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market."); § 1501(a)(2)(I) ("The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold."); § 1501(a)(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs."). Indeed, one of the Act's principal architects labeled amendments to remove the mandate efforts to "gut" or "mortally wound" the bill. *See supra*, p. 6. Moreover, the CBO has estimated that about 16 million of the 32 million individuals that the Act was intended to insure would choose to remain uninsured if there were no individual mandate to obtain insurance. CBO, Effects of Eliminating the Individual Mandate to Obtain Health Insurance (June 16, 2010) (estimating that 4–5 million fewer would obtain employer-based coverage, 5 million fewer would purchase insurance, and 6–7 million fewer would enroll in Medicaid).[17]

The individual mandate was essential not only to Congress' envisioned operation of the Act, but also to another key aspect of the severability inquiry: "the importance of the [invalidated provision] in the original legislative bargain." *Brock*, 480 U.S. at 685. Based on their experiences in States that enacted guaranteed issue and community rating provisions *without* an individual mandate, insurance companies made it clear to Congress that they did not consider the significant costs generated by those twin requirements affordable without the forced subsidy that a mandate to purchase insurance creates. *See supra*, pp. 12–13. As a result, the bill's proponents were acutely aware that the insurance industry would not accept the bitter without the sweet. It would not support the insurance market regulations that the bill's proponents wanted to enact without an individual mandate that would "broaden the health insurance risk pool to include healthy individuals." ACA § 1501(a)(2)(I); *see also* Pet. App. 178a (recognizing that the mandate "mitigate[s] the reforms' cost on insurers by requiring the healthy to buy insurance and pay premiums to insurers to subsidize the insurers' costs in covering the unhealthy"). Thus, as the District Court put it, the individual mandate was, in a very real sense, the "lynchpin of the entire health reform effort." Pet. App. 354a.

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[17] Available at http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf.

2. Precisely because Congress made its understanding of the mandate's key role in the legislation so evident, including in its textual findings, the federal government has conceded throughout this litigation that, issues of "standing" aside, the mandate cannot be severed from the guaranteed issue and community rating provisions. *See, e.g.*, Govt.'s Response Pet. Cert. 10 ("Without the minimum coverage provision, the guaranteed-issue and community-rating provisions would not advance Congress's efforts to make affordable coverage widely available."); Govt.'s 11th Cir. Br. 59 ("the minimum coverage provision is integral to the Act's guaranteed-issue and community-rating provisions"); Govt.'s Mem. Supp. Summ. J. 16 [R.E. 999] ("the minimum coverage provision forms an integral part of the ACA's larger reforms of health insurance industry practices"). But the federal government fails to appreciate the full significance of that unavoidable concession. It not only means that the guaranteed issue and community rating provisions must fall with the mandate; it means that

all the supply-side provisions, and in turn their "offsets," *see infra*, Part II.C, cannot survive the mandate's invalidation.

As the District Court explained, the insurance regulations that stand or fall with the mandate "are the very heart of the Act itself." Pet. App. 356a. Together with the mandate, those provisions not only "were instrumental in passing the Act," Pet. App. 356a, but "were the chief engines that drove the entire legislative effort." Pet. App. 362a; *see also* Pet. App. 356a & nn.28–29 (noting that insurance regulations were repeatedly touted by the President, Congress, and other supporters as central achievements of the ACA). Just as the individual mandate was necessary to ensure that everyone who *can* purchase insurance *will*, the insurance market regulations were necessary to ensure that everyone who *wants* to purchase insurance *can*. And the latter was as popular in some quarters as the former was unpopular in others, so without the ability to guarantee insurance for the uninsured, Congress would never have enacted the ACA.

Simply put, without guaranteed issue and community rating, the impetus for the ACA would disappear, and the Act's whole private insurance expansion would unravel, for insurance companies would remain free to turn away millions of the very same uninsured individuals to whom the Act promised insurance. Accordingly, it is even less plausible to think Congress would have enacted a comprehensive regulatory scheme without the insurance market regulations than to think that Congress would have enacted the insurance market regulations without an individual mandate. Thus, if, as the federal government concedes, the remedial consequences of invalidating the individual mandate necessarily include eliminating the guaranteed issue and community rating provisions, then it is even more evident that the remedial consequences cannot possibly end there. An ACA without the individual mandate and the inextricably intertwined insurance regulations "is legislation that Congress would not have enacted," *Brock*, 480 U.S. at 685, as "the purpose of the Act is ... defeated by the invalidation of th[ose] provision[s]." *New York*, 505 U.S. at 187.

The Eleventh Circuit effectively reached that same conclusion as to the guaranteed issue and community rating provisions—that Congress "would have preferred no [ACA] at all to a[n ACA]" without them, *Free Enter. Fund*, 130 S. Ct. at 3162. *See* Pet. App. 158a. But it failed to follow that conclusion to its logical end. If it is evident that Congress could not have passed the insurance regulations without the mandate, and would not have passed the ACA without the insurance regulations, then the remedy most consistent with Congress' intent is to invalidate the entire ACA, not to sever the mandate and leave the insurance regulations standing. That is true regardless of a court's assessment of the value of those regulations or of their ability to function independently. *But see* Pet. App. 185a (suggesting that presumption of severability should be stronger because insurance regulations will "help consumers who need it most"); Pet. App. 183a (rejecting Congress' finding that the mandate is "essential" because "multiple features of the individual mandate all serve to weaken the mandate's practical influence on the two insurance product reforms"). Congress' judgment, not the court's, is what matters, and if Congress viewed the mandate and the insurance regulations as co-dependent and would not have enacted one without the other, then that evident intent is what controls.

3. For largely the same reasons, the argument that the entire Act must be invalidated is even stronger if the Court holds the ACA's Medicaid expansion unconstitutional. That expansion is every bit as critical to the publicly financed supply side as the guaranteed issue and community rating provisions are to the privately financed supply side when it comes to Congress' objective of near-universal health insurance coverage. Of the 32 million uninsured that Congress envisioned obtaining insurance as a result of the ACA and its individual mandate, Congress expected at least half—*16 million individuals*—to do so through the Medicaid expansion. CBO Estimate 9 (Mar. 20, 2010). Accordingly, the individual mandate plainly could not operate in the manner Congress intended without that expansion, as a huge chunk of the uninsured population that Congress was targeting would be left with no means of complying with the mandate to obtain insurance.

Indeed, without the Medicaid expansion, the ACA would not just fall far short of "near-universal" insurance coverage. It would fail to address in any meaningful manner the problem of providing affordable insurance for the millions of lowest-income individuals that Congress considered in greatest need of assistance. Congress provided no back-up plan for supplying insurance to these 16 million individuals. And, of course, if both the individual mandate and the Medicaid provisions are unconstitutional, then the remnants of the ACA would be wholly unrecognizable to Congress and wholly unable to achieve Congress' goal. With the entirety of the demand side and at least half of the supply side invalidated, Congress' goal of supply meeting demand at the point of near-universal health insurance would be completely unattainable.

While the relationship between the supply side and the demand side of the ACA is uniquely acute with respect to the massive increase in supply that the Medicaid expansion creates, the same basic principle holds true with respect to each of the Act's core provisions: "[T]he policies Congress sought to advance ... can[not] be effectuated," *Regan*, 468 U.S. at 653, by an Act that increases demand without a corresponding increase in supply, or an Act that increases supply without a corresponding increase in demand, because Congress premised its entire regulatory scheme on the notion that each is necessary to make the other effective, and to achieve the overarching objective of near-universal insurance coverage. Accordingly, there is simply no reason to think that Congress would have passed an Act that lacks *any one* of the ACA's core components, let alone an Act that lacks the individual mandate, the insurance market regulations, *and* the Medicaid expansion.

C. The ACA's Remaining Components Cannot Survive Without Its Core Ones.

The federal government cannot and does not deny the co-dependent nature of the relationships at the heart of the massive regulatory web that comprises the ACA. It instead attempts to shift the focus entirely, by insisting that the severability inquiry requires independent analysis of each and every one of the ACA's hundreds of remaining provisions to determine which ones, standing alone, "would properly work independently of the" mandate. Govt.'s Response Pet. Cert. 28. Operating within that artificial framework, the federal government proceeds to pick and choose provisions that it claims are independently functional, such as discrete wellness measures and excise taxes, and contend that the existence of such provisions is sufficient to defeat any argument against severability.

Once again, the federal government misconceives the nature of the severability analysis. The question is not whether some subset of the ACA might be cobbled together to form a fully functional collection of health insurance regulations that are not directly dependent on the individual mandate. As noted, independent functionality is a necessary, but not sufficient, condition for severability. *See supra*, pp. 36–38. "The more relevant inquiry ... is whether the statute will function in a *manner* consistent with the intent of Congress," *Brock*, 480 U.S. at 685, without the mandate. That question must be answered by looking at the Act as a whole, mindful of the basic purposes Congress sought to achieve, not by examining in isolation particular relationships between discrete components.

That broader inquiry into the manner in which Congress intended the ACA to function reveals an interconnectedness that does not stop with the relationship between the mandate and the insurance market regulations, or the relationship between those and the Act's other core supply-side provisions. Congress crafted *the entire Act* to function as "a carefully-balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal." Pet. App. 352a. Because the very "purpose of the Act is … defeated by the invalidation of" any of its core components, *New York*, 505 U.S. at 187, "the policies Congress sought to advance … can[not] be effectuated," *Regan*, 468 U.S. at 653, by removing its hub but leaving the spokes.

That is nowhere more evident than when considering the delicate fiscal balance that Congress designed the ACA to achieve. Congress was acutely aware of the fact that the Act would not pass if it were not scored as deficit neutral, and also was acutely aware of just how much some of the Act's core provisions were going to cost. Most prominently, the CBO estimated just before the House voted on the Act that the Medicaid expansion will cost at least $434 billion over the next decade and the health benefit exchanges will cost another $350 billion. CBO Estimate, Table 2 (Mar. 20, 2010). Congress could not and did not simply authorize that massive and politically unpalatable spending increase and call it a day; to do so would have derailed the entire legislative effort. It authorized that spending increase only after including other components specifically designed to offset it, and only after obtaining the CBO's opinion that those components would achieve the necessary condition of deficit neutrality.[18]

Once that basic legislative dynamic is understood, it is clear that even seemingly unrelated aspects of the Act in fact all work together toward the single central goal of buying and paying for "near-universal coverage." ACA § 1501(a)(2)(D). To take the District Court's example, the relationship between the mandate and the Act's provision requiring businesses to issue 1099 tax forms to certain individuals or corporations may not be obvious at first blush. Pet. App. 362a (citing ACA § 9006). But it is obvious once one takes a step back and realizes that that provision is one of the many "Revenue *Offset* Provisions" in Title IX that were a critical part of the delicate fiscal and legislative compromise that produced the ACA. The same is true as to the excise tax on indoor tanning salons highlighted by the Eleventh Circuit. While that provision may appear to "ha[ve] nothing to do with private insurance," Pet. App. 175a–76a, it, too, is one of Title IX's "revenue offset" provisions. ACA § 9017.

As those integrated budgetary relationships reveal, the case for the balance of the ACA falling with the individual mandate rests not just on "the importance of the [individual mandate] in the original legislative bargain," *Brock*, 480 U.S. at 685, or the inextricably intertwined nature of the mandate and the Act's core supply-side provisions. That remedy also follows from the tenuous fiscal balance upon which the entire Act hinged.

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[18] That is not to suggest that the Act actually *achieves* the fiscal balance that Congress intended. One need not be a cynic to suspect that projected cost savings have a stubborn tendency to underperform, while projected outlays often overperform. But, for purposes of severability analysis, what Congress intended is what matters.

That is particularly true if the Medicaid expansion is invalidated, either on its own or as a consequence of invalidation of the mandate. The ***$434 billion in new federal spending*** that the Medicaid expansion will generate makes it the single most expensive component of the Act. Not surprisingly, given the interest in budget neutrality, that costly expansion is immediately followed in the Act by a collection of massive reductions in ***Medicare*** spending, which Congress envisioned generating ***$455 billion in cost savings***. CBO Estimate, Table 2 (Mar. 20, 2010). That mirror image is no mere coincidence. As the federal government explained, "[w]hen Congress passed the ACA, it was careful to ensure that any increased spending, including on Medicaid, was offset by other revenue-raising and cost-saving provisions." Mem. Supp. Govt.'s Mot. Summ. J. 41 [R.E. 1024].

Just as the desire to provide insurance to the uninsured was the impetus for the ACA as a whole, the need to provide offsets for the enormously costly supply-side provisions such as Medicaid and the exchanges was the critical impetus for the Act's projected cost-saving measures. In an era of massive budget deficits that no one professes to like, Congress presumably had its reasons for not enacting those cost-saving measures earlier. Without the felt-need to offset $434 billion in new Medicaid spending, those offsets would simply not have happened. It thus would do violence to

Congress' intent to have those cost-saving provisions survive the invalidation of the provisions that impelled them in the first place.

That intentional interrelationship among all of the Act's provisions is what the Eleventh Circuit failed to consider when it held the mandate severable from the entirety of the Act. As to every aspect of the ACA except the guaranteed issue and preexisting condition provisions, the court "summarily" rejected any question of severability without even considering how Congress intended those provisions to operate, instead simply noting that "excising the individual mandate from the Act does not prevent the remaining provisions from being 'fully operative as a law.'" Pet. App. 176a, 174a (quoting *Brock*, 480 U.S. at 684). The two District Courts that left much of the ACA standing evinced the same unwillingness to engage in any meaningful analysis of the broader purposes that seemingly discrete segments of the ACA serve. *See Virginia*, 728 F. Supp. 2d at 789 (declaring it "virtually impossible within the present record" to determine which provisions should stand without the mandate), *Goudy-Bachman*, 2011 WL 4072875 at *20 (suggesting any inquiry into how Congress intended various provisions of the Act to operate "would be a[n] immense undertaking, and ultimately speculative at best").

But neither the size nor the speculative nature of the task is any excuse for failing to examine Congress' intent. As to the former, there is no "too big to fail" exception to severability analysis. To be sure, the ACA is an immense and intimidating statute. But that does not make the essential interrelationship of its core provisions and offsetting function of its remaining provisions any less evident. And as to the latter, the inquiry into what the legislature would have intended had it known a provision would be invalidated by the courts is inherently counterfactual and speculative, but that is no excuse for not undertaking it. Many remedial questions faced by courts are counterfactual and speculative, but they are nonetheless critically important to provide an appropriate remedy—and, in this context, to honor Congress' evident intent that the ACA stand or fall with the individual mandate.

Nor does the absence of a non-severability clause in the ACA provide any basis for ignoring all the evidence that Congress intended the individual mandate to be non-severable. The Eleventh Circuit seemed to view that absence as highly relevant, Pet. App. 175a–76a, but such clauses are rare and would make little sense in a vast enactment like the ACA. Both severability and non-severability clauses are typically all-or-nothing propositions, as Congress rarely combs through a bill section by section to explain its intentions as to the severability of each and every provision. One can imagine Congress including a severability clause in a sprawling multi-subject bill to reflect an intent to preserve as much of the act as possible. But in a massive bill with critical central provisions and peripheral complementary provisions, it would make little sense to treat the invalidation of a minor, peripheral provision the same as the invalidation of a core provision of the act. This Court's severability analysis distinguishes between those two circumstances by focusing on Congress' evident intent. A one-size-fits-all non-severability clause would not. But the Court of Appeals bypassed the more sensitive analysis demanded by this Court's cases by giving undue weight to the absence of a non-severability clause.

The Eleventh Circuit compounded that error by dismissing the significance of Congress' decision to eliminate a severability clause during the drafting process. Contrary to the court's conclusion, it is both relevant and probative that Congress included a severability clause in an earlier version of the bill but excluded it from the ACA. To be sure, as the District Court recognized, Pet. App. 355a, the Act's lack of a severability clause does not create a presumption of non-severability. But "[w]here Congress includes … language in an earlier version of a bill, but deletes it prior to enactment, it may be presumed that the [excluded language] was not intended." *Russello v. United States*, 464 U.S. 16, 23–24 (1983). Particularly in the unusual context of an Act with a central provision subjected to constitutional scrutiny even before it became law, there is every reason to think that Congress made a conscious decision when it eliminated a severability clause from an Act that it knew would be subject to serious legal challenges. At a bare minimum, the elimination of that clause should put added focus on Congress' express statements about the interrelationship and co-dependence of the Act's provisions.

In the end, Congress' express and repeated findings that the mandate was "essential" to the Act's broader regulatory goals speak to the question presented here far more directly than the presence or absence of any severability or non-severability clause. Congress made clear that the Act was structured so that it could not achieve its goal of near-universal coverage without the individual mandate. Those textual findings are reinforced by a variety of other indicia of Congress' intent, including: the labeling of amendments designed to remove the mandate as efforts to "gut" or "mortally wound" the bill, the interrelated and co-dependent nature of the supply and demand sides of the Act, and the reality that the Act passed through a series of legislative maneuvers that permitted no changes and made every provision critical. It is thus clear that without the mandate, Congress would not have enacted the supply-side provisions, and without those costly provisions to offset, the balance of the Act never would have emerged.

In these unique circumstances, leaving the remnants of spokes of the ACA in place without its hub runs a very real risk of "substitut[ing] for the law intended by the legislature one they may never have been willing, by itself, to enact." *Pollock*, 158 U.S. at 636. It does not require "speculati[on]" or an "immense" study of every minute detail of the ACA, *Goudy-Bachman*, 2011 WL 4072875 at *21, to arrive at the conclusion plain to all who recall the tortuous and tenuous process that produced it: An ACA without the individual mandate "is legislation that Congress would not have enacted." *Brock*, 480 U.S. at 685.

CONCLUSION

The Court should hold the ACA invalid in its entirety.

Respectfully submitted,

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508

BILL COBB
Deputy Attorney General for Civil Litigation
Office of the Attorney General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

January 6, 2012

Counsel for Petitioners

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Sec. 1408. **Elimination of unintended application of cellulosic biofuel producer credit**
Sec. 1409. **Codification of economic substance doctrine and penalties**
Sec. 1410. **Time for payment of corporate estimated taxes.**

Subtitle F—Other Provisions

Sec. 1501. **Community college and career training grant program**

TITLE II—EDUCATION AND HEALTH

Subtitle A—Education

Subtitle B—Health

Sec. 2301. **Insurance reforms**
Sec. 2302. **Drugs purchased by covered entities.**
Sec. 2303. **Community health centers**

RELEVANT PROVISIONS OF THE PATIENT PROTECTION & AFFORDABLE CARE ACT, PUB. L. NO. 111-148, AS AMENDED BY THE HEALTH CARE & EDUCATION RECONCILIATION ACT OF 2010, PUB. L. NO. 111-152

SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

"Subpart I—General Reform";

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

"SEC. 2704 [42 U.S.C. 300gg-3]. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage."; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg–1)—

(i) by striking the section heading and all that follow through subsection (a);

(ii) in subsection (b)—

(I) by striking "health insurance issuer offering health insurance coverage in connection with a group health plan" each place that such appears and inserting "health insurance issuer offering group or individual health insurance coverage"; and

(II) in paragraph (2)(A)—

(aa) by inserting "or individual" after "employer"; and

(bb) by inserting "or individual health coverage, as the case may be" before the semicolon; and

(iii) in subsection (e)—

(I) by striking "(a)(1)(F)" and inserting "(a)(6)";

(II) by striking "2701" and inserting "2704"; and

(III) by striking "2721(a)" and inserting "2735(a)"; and

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

"SEC. 2701 [42 U.S.C. 300gg]. FAIR HEALTH INSURANCE PREMIUMS.

"(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

"(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

"(A) such rate shall vary with respect to the particular plan or coverage involved only by—

"(i) whether such plan or coverage covers an individual or family;

"(ii) rating area, as established in accordance with paragraph (2);

"(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

"(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

"(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

"(2) RATING AREA.—

"(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

"(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

"(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

"(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

"(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

"SEC. 2702 [42 U.S.C. 300gg–1]. GUARANTEED AVAILABILITY OF COVERAGE.

"(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

"(b) ENROLLMENT.—

"(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

"(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

"(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

"SEC. 2703 [42 U.S.C. 300gg–2]. GUARANTEED RENEWABILITY OF COVERAGE.

"(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

"SEC. 2705 [42 U.S.C. 300gg–4]. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL

PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

"(1) Health status.

"(2) Medical condition (including both physical and mental illnesses).

"(3) Claims experience.

"(4) Receipt of health care.

"(5) Medical history.

"(6) Genetic information.

"(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

"(8) Disability.

"(9) Any other health status-related factor determined appropriate by the Secretary.

"(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

"(1) GENERAL PROVISIONS.—

"(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

"(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.— If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

"(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.— If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

"(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.— If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

"(A) A program that reimburses all or part of the cost for memberships in a fitness center.

"(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

"(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

"(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

"(E) A program that provides a reward to individuals for attending a periodic health education seminar.

"(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

> "(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward

available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

"(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

"(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

"(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

> "(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—
>
> > "(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is

unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

"(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

"(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

"(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

"(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

"(l) WELLNESS PROGRAM DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

"(2) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

"(3) REQUIREMENTS.—

"(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

"(i) will not result in any decrease in coverage; and

"(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

"(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—

"(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

"(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

"(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

"(I) do not create undue burdens for individuals insured in the individual market;

"(II) do not lead to cost shifting; and

"(III) are not a subterfuge for discrimination;

"(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and

"(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

"(m) REPORT.—

"(1) IN GENERAL.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

"(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

"(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

"(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

"(D) the effectiveness of different types of rewards.

"(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

"(n) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection

with this section.

"SEC. 2706 [42 U.S.C. 300gg–5]. NON-DISCRIMINATION IN HEALTH CARE.

"(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

"(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

"SEC. 2707 [42 U.S.C. 300gg–6]. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

"(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

"(b) COST-SHARING UNDER GROUP HEALTH PLANS.—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

"(c) CHILD-ONLY PLANS.—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section

1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

"(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

"SEC. 2708 [42 U.S.C. 300gg–7]. PROHIBITION ON EXCESSIVE WAITING PERIODS.

"A group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.

"SEC. 2709 [42 U.S.C. 300gg–8]. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

"(a) COVERAGE.—

"(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

"(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

"(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

"(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

"(2) ROUTINE PATIENT COSTS.—

"(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

"(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

"(i) the investigational item, device, or service, itself;

"(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

"(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

"(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

"(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

"(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

"(2) Either—

"(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

"(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

"(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

"(d) APPROVED CLINICAL TRIAL DEFINED.—

"(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

"(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

"(i) The National Institutes of Health.

"(ii) The Centers for Disease Control and Prevention.

"(iii) The Agency for Health Care Research and Quality.

"(iv) The Centers for Medicare & Medicaid Services.

"(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

"(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

"(vii) Any of the following if the conditions described in paragraph (2) are met:

"(I) The Department of Veterans Affairs.

"(II) The Department of Defense.

"(III) The Department of Energy.

"(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

"(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

"(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

"(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

"(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

"(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term 'life-threatening condition' means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

"(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

"(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.".

SEC. 1501. [42 U.S.C. 18091]. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, andwill increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South- Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

"Sec. 5000A. Requirement to maintain minimum essential coverage.

"SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

"(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.— An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

"(b) SHARED RESPONSIBILITY PAYMENT.—

"(1) IN GENERAL.— If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

"(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

"(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

"(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

"(c) AMOUNT OF PENALTY.—

"(1) IN GENERAL.— The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

"(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

"(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

"(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1⁄12 of the greater of the following amounts:

"(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

"(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

"(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

"(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

"(i) 1.0 percent for taxable years beginning in 2014.

"(ii) 2.0 percent for taxable years beginning in 2015.

"(iii) 2.5 percent for taxable years beginning after 2015.

"(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

"(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.

"(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.— If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

"(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

"(i) $695, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

"(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

"(i) the modified *adjusted* gross income of the taxpayer, plus

"(ii) the aggregate modified *adjusted* gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(C) MODIFIED ADJUSTED GROSS INCOME.— The term 'modified gross income' means gross income—

"(i) any amount excluded from gross income under section 911, and

"(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

"(2) RELIGIOUS EXEMPTIONS.—

"(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

"(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1) and

"(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

"(B) HEALTH CARE SHARING MINISTRY.—

"(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

"(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

"(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

"(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

"(III) members of which retain membership even after they develop a medical condition,

"(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

"(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

"(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

"(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

"(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

"(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

"(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

"(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

"(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

"(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

"(2) TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

"(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

"(4) MONTHS DURING SHORT COVERAGE GAPS.—

"(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

"(B) SPECIAL RULES.—For purposes of applying this paragraph—

"(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

"(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

"(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

"(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

"(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

"(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:

"(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

"(i) the Medicare program under part A of title XVIII of the Social Security Act, "(ii) the Medicaid program under title XIX of the Social Security Act,

"(iii) the CHIP program under title XXI of the Social Security Act,

"(iv) the TRICARE for Life program,

"(v) the veteran's health care program under chapter 17 of title 38, United States Code, or

"(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

"(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

"(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

"(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

"(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

"(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

"(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

"(B) any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

"(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—

"(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

"(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

"(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

"(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

"(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

"(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

"(g) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) SPECIAL RULES.—Notwithstanding any other provision of law—

"(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

"(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

"(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

"(ii) levy on any such property with respect to such failure.".

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

"CHAPTER 48—MAINTENANCE OF
MINIMUM ESSENTIAL COVERAGE.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking "or" at the end of subclause (VI);

(B) by adding "or" at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

"(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);".

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

"(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.".

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

(i) in paragraph (24), by striking "or" at the end;

(ii) in paragraph (25), by striking the period and inserting "; or"; and

(iii) by adding at the end the following:

"(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).".

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting "subsection (y) and" before "section 1933(d)"; and

(B) by adding at the end the following new subsection:

"(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

"(1) AMOUNT OF INCREASE.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to—

"(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

"(B) 95 percent for calendar quarters in 2017;

"(C) 94 percent for calendar quarters in 2018;

"(D) 93 percent for calendar quarters in 2019; and

"(E) 90 percent for calendar quarters in 2020 and each year thereafter.

"(2) DEFINITIONS.—In this subsection:

"(A) NEWLY ELIGIBLE.—The term 'newly eligible' means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

"(B) FULL BENEFITS.—The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).".

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

"(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

"(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.".

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking "and (XIV)" and inserting "(XIV)" and by inserting "and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)" before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking "100" and inserting "133".

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xii);

(ii) by inserting "or" at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

"(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),".

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(i)(VIII)," after "1902(a)(10)(A)(i)(VII),".

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u– 7(a)(1)(B)) is amended by inserting "subclause (VIII) of section 1902(a)(10)(A)(i) or under" after "eligible under".

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking "and" at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting "; and"; and

(C) by inserting after paragraph (73) the following new paragraph:

"(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg)."; and

(2) by adding at the end the following new subsection:

"(gg) MAINTENANCE OF EFFORT.—

"(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE

EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

"(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

"(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on

December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

"(4) DETERMINATION OF COMPLIANCE.—

"(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.— A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO

COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).".

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each";

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)" after "subsection (a)(1),";

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses

(vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services."; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

"(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph

(1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

"(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).".

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking "and" at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting "; and"; and

(C) by inserting after paragraph (74) the following new paragraph:

"(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

"(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

"(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

"(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.".

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national

and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.— Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking "or" at the end;

(ii) in subclause (XIX), by adding "or" at the end; and

(iii) by adding at the end the following new subclause:

"(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);" and

(B) by adding at the end the following new subsection:

"(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xiii);

(ii) by inserting "or" at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

"(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),".

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(ii)(XX)," after "1902(a)(10)(A)(ii)(XIX),".

(C) Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by subsection (a)(4)(B), is amended by inserting "or clause (ii)(XX)" after "clause (i)(VIII)".

PETITIONER'S BRIEF

NOS. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL.,

v.

KATHLEEN SEBELIUS, ET AL.

STATE OF FLORIDA, ET AL.,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit

BRIEF FOR PRIVATE PETITIONERS ON SEVERABILITY

KAREN R. HARNED
NFIB SMALL BUSINESS
LEGAL CENTER
1201 F St. NW, Suite 200
Washington, DC 20004

PROF. RANDY E. BARNETT
GEORGETOWN UNIV.
LAW CENTER
600 New Jersey Ave. NW
Washington, DC 20001

MICHAEL A. CARVIN
Counsel of Record
GREGORY G. KATSAS
C. KEVIN MARSHALL
HASHIM M. MOOPPAN
YAAKOV M. ROTH
JONES DAY
51 Louisiana Ave. NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

Counsel for Private Petitioners

QUESTION PRESENTED

Congress effected a sweeping and comprehensive restructuring of the Nation's health-insurance markets in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 109 (collectively, the "Act" or "ACA"). In No. 11-398, this Court is reviewing whether Congress exceeded its Article I authority when it enacted the ACA's mandate that virtually every individual American obtain health insurance. 26 U.S.C.A. § 5000A(a). Here, the question presented is:

Whether the remainder of the Act must be invalidated in whole or in part because it cannot be severed from the individual mandate.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Three private individuals or organizations were Plaintiffs-Appellees below and are Petitioners in No. 11-393 and Respondents (by rule) in No. 11-400: National Federation of Independent Business ("NFIB"); Kaj Ahlburg; and Mary Brown. NFIB is a nonprofit mutual benefit corporation that promotes and protects the rights of its members to own, operate, and grow their businesses across the fifty States and the District of Columbia. NFIB is not a publicly traded corporation, issues no stock, and has no parent corporation. There is no publicly held corporation with more than a 10% ownership stake in NFIB.

26 States, by and through their Attorneys General or Governors, were Plaintiffs-Appellees/Cross-Appellants below and are Petitioners in No. 11-400 and Respondents (by rule) in No. 11-393: Alabama; Alaska; Arizona; Colorado; Florida; Georgia; Idaho; Indiana; Iowa; Kansas; Louisiana; Maine; Michigan; Mississippi; Nebraska; Nevada; North Dakota; Ohio; Pennsylvania; South Carolina; South Dakota; Texas; Utah; Washington; Wisconsin; and Wyoming.

Six federal officers or agencies were Defendants-Appellants/Cross-Appellees below and are Respondents in Nos. 11-393 & 11-400: Kathleen Sebelius, in her official capacity as Secretary of Health and Human Services; Timothy F. Geithner, in his official capacity as Secretary of the Treasury; Hilda L. Solis, in her official capacity as Secretary of Labor; and the United States Departments of Health and Human Services, of the Treasury, and of Labor.

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BRIEF FOR PRIVATE PETITIONERS

Private Petitioners respectfully submit this brief arguing that the individual mandate is not severable from the remainder of the Act.[1]

OPINIONS BELOW

The opinion of the court of appeals (Pet.App. 1a-273a) is reported at 648 F.3d 1235. The summary-judgment opinion of the district court (Pet.App. 274a-368a) is reported at 780 F. Supp. 2d 1256. The district court's motion-to-dismiss opinion (Pet.App. 394a-475a) is reported at 716 F. Supp. 2d 1120.

JURISDICTION

The Eleventh Circuit entered judgment on August 12, 2011. The petitions for writs of certiorari were filed on September 27 and 28, 2011. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The appendix hereto reproduces selected provisions from the Act.

STATEMENT OF THE CASE

The Act reflects an intricate deal that emerged from one of the most hard-fought and narrowly decided legislative battles in recent memory. It produced a "comprehensive and complex regulatory scheme" (Pet.App. 22a) that proponents claimed would achieve near-universal health-insurance coverage and reduce health-insurance costs—without increasing the federal budget deficit.

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[1] To avoid confusion, all "Pet.App." citations reference the appendix to the Government's certiorari petition in No. 11-398. "RE" citations reference the Eleventh Circuit Record Excerpts.

A. The Act's Passage

1. Origins Of The Act

Comprehensive change of the Nation's system of health insurance was a central issue in the 2008 Democratic presidential primary, with each major candidate outlining proposals to achieve near-universal coverage while lowering costs. *See, e.g.*, Michael Cooper, *It Was Clinton vs. Obama on Health Care*, N.Y. TIMES, Nov. 16, 2007, at A30. Then-Senator Hillary Clinton was the first to propose a mandate that every individual purchase health insurance—a proposal that then-Senator Barack Obama sharply criticized. *Id.* Clinton responded that universal coverage would be impossible absent an individual mandate. *Id.*

After taking office, President Obama's position on an insurance mandate changed. The shift began after the insurance industry's two main trade associations offered to support comprehensive regulation on the condition that any bill contain "an enforceable mandate for individual coverage." Robert Pear, *Health Insurers Offer to Accept All Applicants, On Condition*, N.Y. TIMES, Nov. 20, 2008, at A30. This offer led to planning sessions between congressional leaders and major healthcare stakeholders, at which the centrality of the mandate became clear. *See, e.g.*, Robert Pear, *Health Care Industry in Talks to Shape Policy*, N.Y. TIMES, Feb. 20, 2009, at A16. In the face of this pressure, the President signaled a willingness to depart from his campaign pronouncements. Robert Pear, *Obama Open to Mandate That People Own Coverage*, N.Y. TIMES, June 3, 2009, at A17. Likewise, the chairs of critical congressional committees agreed "to plow ahead on the assumptions that individuals would be required to carry insurance" and "that most employers would be required to help pay for it." Robert Pear, *Team Effort In the House To Overhaul Health Care*, N.Y. TIMES, Mar. 18, 2009, at A12.

2. Goals Of The Legislative Effort

For proponents of change, any legislation had to serve two fundamental goals: (1) ensuring nearly universal coverage, in particular by prohibiting what were described as discriminatory and abusive practices by insurance companies, such as the refusal to insure sick individuals and the pricing of insurance based on individual actuarial risk; and (2) reducing the overall cost of health insurance.

The President made clear throughout the process that his core goal was to expand coverage, especially by eliminating the putative insurer abuses. As he explained in his 2010 State of the Union address:

> I took on health care because of the stories I've heard from Americans with preexisting conditions whose lives depend on getting coverage; patients who've been denied coverage; families—even those with insurance—who are just one illness away from financial ruin. ...
>
> The approach we've taken would protect every American from the worst practices of the insurance industry. It would give small businesses and uninsured Americans a chance to choose an affordable health care plan in a competitive market.[2]

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[2] http://www.whitehouse.gov/the-press-office/remarks-president-state-union-address.

Legislators echoed the sentiment. *E.g.*, 155 Cong. Rec. S13295, 13306 (daily ed. Dec. 16, 2009) (Sen. Johnson) ("This legislation ... puts an end to insurance industry abuses that have denied coverage to hard-working Americans ....").

Equally "driving" the legislative effort, though, was the fact that costs were "exploding." Robert Pear, *Obama's Health Plan, Ambitious in Any Economy, Is Tougher In This One*, N.Y. TIMES, Mar. 2, 2009, at A14 (quoting Melody C. Barnes, director of the President's Domestic Policy Council). Once again, President Obama was emphatic:

> Then there's the problem of rising cost. ... [This is why] so many employers–especially small businesses—are forcing their employees to pay more for insurance, or are dropping their coverage entirely ....
>
> The plan I'm announcing tonight ... will slow the growth of health care costs for our families, our businesses, and our government. It's a plan that asks everyone to take responsibility for meeting this challenge—not just government, not just insurance companies, but everybody including employers and individuals.

Remarks by the President to a Joint Session of Congress on Health Care, Sept. 9, 2009 ("*Remarks to Congress*").[3]

Then-Speaker Pelosi, and countless other legislators, echoed this refrain:

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[3] http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/

> We all know that the present ... health insurance system in our country is unsustainable. We simply cannot afford it. ... The best action that we can take on behalf of America's family budgets and on behalf of the Federal budget is to pass health care reform.

156 Cong. Rec. H1891, 1896 (daily ed. Mar. 21, 2010); *see also, e.g.*, 156 Cong. Rec. S1923, 1931 (daily ed. Mar. 24, 2010) (Sen. Levin) ("At its heart, this bill ... aim[s] to tackle the central problems of our health care system—rising costs and the insecurity many Americans rightly feel about the lack of dependability of their insurance.").

3. Critical Constraints

Despite the urgency with which the President and congressional leaders pushed forward, they faced many obstacles to obtaining the necessary votes.

Significant disagreements, even among proponents of comprehensive legislation, left little room for workable compromise. For example, many supported a strong "public option," *i.e.*, a government-run insurer, which was said to "remove the profit motive as an obstacle to medical care";[4] others argued that the "public option" would produce inefficient and unfair competition with the private sector; and still others offered compromise solutions involving more limited public plans. *See* Robert Pear, *Schumer Points to a Middle Ground on Government-Run Health Insurance*, N.Y. TIMES, May

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[4] David M. Herszenhorn, *Public Option Keeps Toehold in Senate Deal on Health Bill*, N.Y. TIMES, Dec. 9, 2009, http://www.nytimes.com/2009/12/10/health/policy/10health.html?scp=32&sq=health+care+public+option&st=nyt.

5, 2009, at A20. Many legislators were concerned about imposing the onerous taxes that would be necessary to fund an expansion in health-insurance coverage. *See* David M. Herszenhorn, *Democrats Are at Odds on Financing Health Care*, N.Y. TIMES, July 10, 2009, at A14.

Moreover, the Act had no hope of passing if it was scored by the Congressional Budget Office ("CBO") as increasing the federal deficit. President Obama was emphatic that "[h]ealth care reform must not add to our deficits over the next 10 years—it must be at least deficit neutral." Letter from President Obama to Senators Kennedy and Baucus (June 3, 2009).[5] The President bluntly warned: "I will not sign a plan that adds one dime to our deficits—either now or in the future." *Remarks to Congress*, *supra*. The Senate Majority Leader agreed that any bill had to not only "lower the cost of staying healthy" but also "reduce the national debt."[6] And key, centrist Senators likewise insisted on this constraint. *See, e.g.*, Robert Pear & David M. Herszenhorn, *Democrats Are Considering Additional Tax on Insurers*, N.Y. TIMES, Oct. 9, 2009, at A19 ("[W]e all set goals and we really, really, really worked hard to stay within those goals of making sure that it was deficit-neutral." (quoting Sen. Lincoln)); *Nelson: Bill Must Be Deficit Neutral*, ORLANDO SENTINEL, Oct. 2, 2009, at A18.

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[5] http://www.whitehouse.gov/the_press_office/Letter-from-President-Obama-to-Chairmen-Edward-M-Kennedy-and-Max-Baucus.

[6] Press Conference of Sen. Harry Reid at 0:29-0:34, Dec. 19, 2009, *available at* http://reid.senate.gov/newsroom/121909_finalbill.cfm.

4. Early Versions Of The Act

The Act's first precursor was released by the House Ways and Means Committee. The draft bill:

- Required that insurance companies provide insurance on a "guaranteed-issue" basis, *i.e.*, that they provide coverage for all consumers, regardless of any pre-existing health conditions. H.R.__ [Discussion Draft], §§ 111-112 (June 19, 2009).[7]
- Required "community-rated" premiums—*i.e.*, premiums reflecting average costs in a particular region, but (with limited exceptions) not individual characteristics reflecting actuarial risk. *Id.* § 113.
- Provided that "[i]n the case of any individual who does not [maintain insurance] at any time during the taxable year, there is hereby imposed a tax." *Id.* § 401.

This draft was subject to intense negotiations, and sharp disagreements led to three different committee versions.[8] Ultimately, the House passed, by a vote of 220 to 215, a version that retained the guaranteed-issue and community-rating provisions, and imposed a tax on individuals without insurance (but not a direct mandate to buy it). H.R. 3962, 111th Cong. §§ 211-213, 501 (Nov. 7, 2009). The bill also included a severability clause, providing that if any provision were held to be unconstitutional, the rest of the bill would remain in effect. *Id.* § 255.

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[7] http://waysandmeans.house.gov/media/pdf/111/hrdraft.pdf.

[8] David M. Herszenhorn & Robert Pear, *House Health Care Bill Criticized as Panel Votes for Public Plan*, N.Y. TIMES, July 31, 2009, at A11.

The initial bill reported from committee in the Senate, like the House bill, imposed guaranteed-issue and community-rating rules on insurers. Affordable Health Choices Act § 101, S. 1679, 111th Cong. (as reported by Sen. Comm. on Health, Educ., Labor, and Pensions Sept. 17, 2009). In contrast to the House bill, however, the Senate bill did not apply a tax if an individual was uninsured. Rather, to comport with the President's campaign pledge not to raise taxes on families earning under $250,000 per year, it instead imposed a direct legal requirement that "[e]very individual shall ensure that such individual ... is covered under qualifying coverage at all times during the taxable year." *Id.* § 161; *see also* Adam Nagourney & David M. Herszenhorn, *Republicans Call Health Legislation a Tax Increase*, N.Y. TIMES, Oct. 2, 2009, at A22.

Following intense negotiation among the congressional leadership, a final Senate bill was introduced. S. Amend. No. 2786 to H.R. 3590, 111th Cong. (introduced Nov. 19, 2009). This version included guaranteed-issue and community-rating rules, like each of its predecessors, and it also imposed an individual insurance mandate, with compliance enforced by "payment of [a] penalty." *Id.* §§ 1201, 1501. Notably, however, the Senate amendment deleted the severability clause that had been included in the House bill. Following further amendments, exactly sixty Senators—just enough under Senate rules, Sen. R. XXII—ended debate on the bill on December 23, 2009; and with the same sixty votes, the Senate passed the bill the next day.[9]

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[9] Bill Summary and Status, H.R. 3590, *available at* http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:@@@X.

5. Final Passage And Reconciliation

Just a few weeks later, Scott Brown won a special election to fill a Senate seat previously occupied by Paul Kirk, who had voted for the Senate bill. A central plank in Brown's campaign was that he had "vowed to oppose" the bill. Michael Cooper, *G.O.P. Senate Victory Stuns Democrats*, N.Y. TIMES, Jan. 19, 2010, at A1. Thus, when he was sworn in, there were no longer sixty supportive Senators, so a filibuster could not be avoided on any future votes.

This was critical, because no single bill had yet been enacted by both houses of Congress, as required by the Constitution. Ordinarily, different House and Senate versions of a bill are reconciled by a conference committee into a final bill, which each house then must pass. But, in this case, any bill remotely resembling the one passed by the Senate in December 2009 was sure to be filibustered in the reconstituted Senate. Accordingly, the House had no choice, if it wanted such a bill, but to pass it in the *exact* form in which it had passed the Senate.

The only way for Congress then to make any changes was to amend the bill through a procedure known as budget reconciliation. By statute, budget reconciliation bills may be debated in the Senate for only twenty hours, 2 U.S.C. § 641(e)(2), which makes filibusters impossible. However, such bills may include only provisions that have direct budgetary impacts. *Id.* § 644(b)(1)(A). Congress was thus precluded from making any *non-budgetary* amendments to the Senate bill.

With no other option, the House adopted a rule providing for all-or-nothing consideration of the Senate bill without amendments, *see* H.R. Res. 1203, 111th Cong. (2010), and passed the Senate bill (the Patient Protection and Affordable Care Act) by a final vote of 219 to 212. The House and Senate then passed, by simple majority vote, the Health Care and Education Reconciliation Act of 2010, a reconciliation bill that adopted certain budgetary amendments. David M. Herszenhorn & Robert Pear, *Final Votes in Congress Cap Battle over Health*, N.Y. TIMES, Mar. 26, 2010, at A17.

B. Operation Of The Act

The Act operates through nine titles (as amended by a tenth). Its heart, contained in Title I, expands insurance coverage by simultaneously requiring insurers to provide broad coverage to all comers and imposing on individuals and employers a "shared responsibility" to buy it. Title I also assists individuals in satisfying the mandate by subsidizing their purchase of insurance through newly created "Health Benefit Exchanges." Title II fills remaining gaps in coverage, by expanding Medicaid and other public insurance programs. Titles III through VIII aim to increase the availability of various services and the efficiency of health-insurance coverage—*e.g.*, by increasing preventative-care coverage, reducing fraud and abuse in public insurance, and expanding prescription-drug coverage. Finally, Title IX imposes various revenue-raising measures to "offset" the spending measures in the Act.

1. Insurance Regulations

The Act comprehensively regulates various aspects of health insurance. Specifically, Congress banned "discrimination based on health status," by requiring insurance companies to provide "guaranteed-issue" coverage and charge "community-rated" premiums. 42 U.S.C.A. §§ 300gg, 300gg-1(a), 300gg-3(a), 300gg-4. Relatedly, Congress limited insurers' ability to restrict the scope and duration of covered services. Insurers thus may not: refuse to pay for certain services, such as "preventative health services," *id.* §§ 300gg-6(a), 300gg-13; impose annual or lifetime limits on coverage, *id.* § 300gg-11; rescind coverage absent fraud, *id.* § 300gg-12; impose "unreasonable" premium increases, *id.* § 300gg-4(a)(1); or require more than a maximum level of "cost sharing" (*e.g.*, deductibles) from insured individuals, *id.* § 18022(c)(3)(A). *See* Pet.App. 26a-31a (describing the Act's restrictions on insurance).

The Act thus effectively requires insurers to offer health insurance to any individual, no matter how sick, and to cover limitless amounts of healthcare for the life of the insured, at average rates that ignore actuarial risk. These measures serve the Act's goal of expanding health-insurance coverage and curbing "discriminatory" insurance practices; but by themselves, they severely undermine the Act's other principal goal of reducing health-insurance costs. *See* 42 U.S.C.A. § 18091(a)(2)(I). As the Eleventh Circuit noted, according to the CBO, by "requir[ing] private insurers ... to cover the unhealthy," but forbidding them from "pric[ing] that coverage [based] on actuarial risks," the Act's insurance regulations will raise insurance costs in the individual market by *27 to 30%.* Pet.App. 126a n.107, 129a n.114.[10]

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[10] Citing CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6 (Nov. 30, 2009) ("CBO, *Premiums*"), http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.).

2. Individual Mandate

To counteract the cost-increasing effect of the Act's insurance regulations, Congress heeded the insurance industry's lobbying to impose a mandate for individuals to purchase insurance coverage.[11]

The mandate provides:

> An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

26 U.S.C.A. § 5000A(a). This legal "requirement" to obtain health insurance is enforced by a monetary "penalty" for each month of non-compliance. *Id.* § 5000A(b).

The mandate was intended to counteract the inflationary effects of the Act's insurance regulations in two distinct ways. *First*, and most significantly, the mandate directly subsidizes insurance companies by forcing healthy individuals to buy extensive coverage on economically disadvantageous terms, namely, at the same price as unhealthy persons. *Second*, Congress believed the mandate, along with other provisions of the Act, would reduce the costs imposed on doctors, patients, and insurers as a result of uncompensated care.

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[11] *See, e.g.*, Addressing Insurance Market Reform: Hearing Before the S. Comm. on Health, Education, Labor & Pensions, 111th Cong. (2009) (submission of Ronald A. Williams, Chairman & CEO, Aetna, Inc.) ("Since 2005, we at Aetna have been speaking out in support of an individual coverage requirement ....").

a. The most significant effect of the mandate is to subsidize insurers, which will in turn hold down the premiums paid by individuals and families. By forcing "millions of new customers [in]to the health insurance market," the mandate increases the number of customers for insurers. 42 U.S.C.A. § 18091(a)(2)(C). As Senator Franken explained in justifying the insurance regulations, "we are giving these companies a huge influx of new business." 156 Cong. Rec. S1821, 1862 (daily ed. Mar. 23, 2010). Moreover, this "huge influx" is highly profitable, because it consists of primarily *healthy* individuals, who have sensibly decided that comprehensive insurance is not financially worthwhile. The statutory findings expressly state that the mandate's "broaden[ing of] the health insurance risk pool to include healthy individuals ... will lower health insurance premiums" and is therefore "essential to creating effective health insurance markets." 42 U.S.C.A. § 18091(a)(2)(I).

The mandate does not target, and was not needed to capture, the sick or the poor. Regardless of the mandate, unhealthy individuals will voluntarily purchase insurance at favorable rates, under the guaranteed-issue and community-rating provisions.[12] And impoverished individuals will generally be covered either by the Act's subsidies for participation in health-insurance exchanges or by the expanded Medicaid program. *See infra* at 19-22. Accordingly, the mandate targets healthy individuals who could afford insurance but believe, given their infrequent healthcare needs, that its cost is not warranted, particularly given the 30% increase in premiums caused by the Act's insurance regulations.[13]

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[12] CBO, *Premiums*, 19 ("[I]n the absence of [the mandate], people who are older and more likely to use medical care would be more likely to enroll in nongroup plans" than "people who are younger and expect to use less medical care.").

Conscripting these individuals into the insurance market will greatly reduce the average payouts required from insurance companies. That is why the mandate *lowers* prices for voluntary insurance customers, inverting the normal economic axiom that increased demand *increases* prices. Specifically, the mandate is supposed to lower premiums in the non-group market by *15-20%*, offsetting roughly two-thirds of the increase caused by the Act's insurance regulations.[14] Based on CBO estimates, this subsidy is worth between $28 and $39 billion in 2016 alone.[15] As the Eleventh Circuit noted, Congress used this subsidy "to mitigate [the Act's] regulatory costs on private insurers." Pet.App. 129a.[16]

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[13] CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010) ("CBO, *Effects*"), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf ("[T]he elimination of the mandate would reduce insurance coverage among healthier people to a greater degree than it would reduce coverage among less healthy people.").

[14] CBO, *Effects*, 2.

[15] The average premium in the non-group market in 2016 will be $5,800 after the reduction, which would mean the mandate lowered premiums by $1,024 to $1,450 for each of the 27 million voluntary participants. CBO, *Premiums*, 6; CBO, *Effects*, 2.

[16] Indeed, as the Government explained below, Congress believed that "the absence of a minimum coverage requirement [to offset] guaranteed-issue and community-rating requirements had undermined health care reform efforts in several states." Govt. Br. at 31 (11th Cir. Apr. 1, 2011).

In addition to reducing the average payouts by insurance companies, Congress also believed that the mandate protected insurers' incoming revenue stream, by preventing a type of "adverse selection" thought to be enabled by the Act's guaranteed-issue and community-rating rules. Namely, people now "would wait to purchase health insurance until they need[] care." 42 U.S.C.A. § 18091(a)(2)(I). Indeed, some proponents of the mandate claimed that this "adverse selection" phenomenon "tends to lead to a death spiral of individual insurance."[17] Rightly or wrongly, Congress thought the mandate "essential" to prevent such adverse selection. *Id.*[18]

b. In addition to directly subsidizing insurance companies by conscripting healthy individuals,

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[17] Statement of Uwe Reinhardt, Making Health Care Work for American Families, Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Health, 111th Cong. 11 (Mar. 17, 2009).

[18] As the Eleventh Circuit explained, Congress' concerns about this kind of "adverse selection" are both highly implausible and completely speculative. One "cannot literally purchase insurance on the way to the hospital," because "the Act permits insurers to restrict enrollment to a specific open or special enrollment period," and it additionally allows waiting periods for general coverage eligibility. Pet.App. 178a n.139 (citing 42 U.S.C.A. §§ 300gg-1(b), 300gg-7). Thus, an individual hoping to game the Act's insurance regulations would have to gamble that, if he contracted some catastrophic illness, he would be able to wait until an open enrollment period (generally one month out of each year) and then wait an additional period for coverage to kick in. In this regard, neither Congress nor the CBO offered even a rough estimate, based on the States' experience or otherwise, of the extent to which people might delay purchasing insurance because of the availability of guaranteed-issue and community-rating rules.

Congress also thought the mandate would "lower health insurance premiums" by reducing the alleged premium increase of "over $1,000 a year" attributable to uncompensated care provided to the uninsured. 42 U.S.C.A. § 18091(a)(2)(F). Congress found that the uninsured "fail to pay the full cost of the services they consume" and instead "shift the costs of their uncompensated care—totaling $43 billion in 2008—to health care providers." Govt. Cert. Pet. 6 (citing 42 U.S.C.A. § 18091(a)(2)(A)). Congress believed that providers in turn "pass on the cost to private insurers," which "increases family premiums by on average over $1,000 a year." 42 U.S.C.A. § 18091(a)(2)(F). Congress thus thought that, "[b]y significantly reducing the number of the uninsured, the [mandate] … will lower … premiums." *Id.*

In fact, the mandate will have virtually no impact on uncompensated care. As the Eleventh Circuit explained, the data on which Congress relied for its $43 billion estimate of uncompensated care show that the vast majority of this sum is attributable to people *not* affected by the mandate. First, $15 billion is attributable to people who will become eligible for Medicaid under the Act, and are therefore likely to obtain insurance without the mandate. Pet.App. 127a. Another $8.7 billion is provided to individuals with pre-existing conditions, who will buy coverage *voluntarily* under the new guaranteed-issue and community-rating regulations. *Id.* 127a-28a. An additional $8.1 billion is attributable to aliens not subject to the mandate. *Id.* 127a. And another $3.3 billion is caused by the failure of individuals *with insurance* to pay out-of-pocket expenses such as deductibles. *Id.* 128a. Thus, the amount of uncompensated care even *potentially* attributable to individuals affected by the mandate is less than ***$8 billion***, 0.33% of the $2.4 trillion healthcare market. *Id.*

Moreover, other data show that even this $8 billion figure is substantially overstated. As a threshold matter, many uninsured individuals obtain *no* healthcare in a given year, and most others actually pay in full. The uninsured on average obtain *no* uncompensated care from non-emergency providers and actually pay *more* for those services than the insured do.[19] As for emergency care, less than 20% of the full-year uninsured visit emergency rooms, which is the only place where federal law requires that the indigent receive limited "stabilizing" care.[20]

Thus, as detailed by *amicus curiae* in the court below, the voluntarily uninsured obtain, on average, only $854 in healthcare services per year.[21] And when it comes to *emergency-room care*, "the data show that the targets of the mandate consume only $56 per year on average in total emergency-room care, which includes both the mandated emergency stabilization care (which may still be billed to patients) and the more routine care administered there."[22] Given CBO estimates that the individual mandate will cause 16 million people to buy insurance,[23] it will only affect people consuming about ***$900 million*** (16 million x $56) in emergency-room care, and an even smaller amount of *uncompensated* care. The full $900 million equals approximately 2% of Congress' inflated estimate of $43 billion in uncompensated care, and .038% of the $2.4 trillion healthcare market. In short, the mandate targets individuals who are *unlikely* to obtain healthcare at all and who mostly *pay* when they do.

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[19] Jonathan Gruber & David Rodriquez, *How Much Uncompensated Care Do Doctors Provide?*, 26 J. HEALTH ECON. 1151, 1159-61 (2007).

[20] CDC, *Health*, 337; 42 U.S.C. § 1395dd.

[21] *See* Amicus Curiae Economists Br. at 13-16 (11th Cir. May 11, 2011).

[22] *Id.*

In truth, Congress's professed concern with cost-shifting attributable to uncompensated care is somewhat ironic, given the extent to which the Act affirmatively requires cost-shifting in other respects. By any measure, uncompensated care attributable to those affected by the individual mandate is a small fraction of the $28 to $39 billion in costs that will be shifted from the new, healthier customers affected by the individual mandate to insurance companies and their voluntary, less-healthy customers.

In addition, even after 2014, the Act does not allow insurers to subject those who refuse to buy insurance to pre-existing condition bans or higher premiums. Moreover, the Act exempts millions of individuals from the penalty for violating the mandate, *see* 26 U.S.C.A. § 5000A(e), and the relatively modest penalties are not used to offset the costs of insuring those who purchase insurance only once ill. For all of these reasons, private insurance customers will continue to bear the cost of millions of people failing to buy insurance after 2014.

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[23] CBO, *Effects* 2.

Moreover, Medicaid pays substantially lower rates than private insurers.[24] On Congress' view that hospitals shift unrecovered costs to private insurers, such rates would likely shift costs to private insurance. Indeed, the Act exacerbates that cost-shifting by *expanding* Medicaid while *cutting* Medicaid reimbursements. Likewise, "[t]he current tax exclusion for the premiums of employment-based health plans provides a subsidy of about 30 percent" to those receiving employer-based insurance, another amount far greater than any subsidy for uncompensated care provided to the voluntarily uninsured.[25]

3. Exchanges And Federal Subsidies

Title I of the Act also requires the creation of state "Health Benefit Exchanges" by January 1, 2014. 42 U.S.C.A. § 18031. These are marketplaces through which individuals (or small businesses) can purchase the mandated insurance.

To sell insurance on an exchange, an insurer must be certified as offering "qualified health plans," *id.* § 18031(d)(2)(B)(I), which must pay for certain "essential health benefits," *id.* § 18021(a)(1)(B). These include a wide range of services including substance-abuse treatment, behavioral health treatment, prescription drugs, rehabilitative services, and preventive services. *Id.* § 18022(b)(1). Insurers must limit "cost sharing" by insureds—*i.e.*, out-of-pocket costs like deductibles. *Id.* § 18022(c).

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[24] CBO, *Key Issues in Analyzing Major Health Insurance Proposals*, at 114-15 (Dec. 2008), http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf

[25] *Id.* at XVII.

Insurers also must calibrate their plans to pay for a specific percentage of the healthcare costs for all enrollees: A "bronze" plan must pay for 60% of the healthcare costs obtained by enrollees, a "silver" plan must pay 70%, a "gold" plan 80%, and a "platinum" plan 90%. *Id.* § 18022(d)(1). Insurers may offer the option of a "catastrophic plan," which provides no benefits until a certain level of out-of-pocket costs is met, but only to individuals who are under 30 or exempt based on economic hardship from the penalty for violating the mandate. *Id.* § 18022(e).

The Act provides extensive subsidies for low-income individuals to participate in exchanges. 26 U.S.C.A. § 36B; 42 U.S.C.A. § 18071. Specifically, tax credits are available for individuals who purchase health insurance through an exchange and have income between 100% and 400% of poverty levels. 26 U.S.C.A. § 36B(a), (b), (c)(1). The credits are tied to the lesser of (i) the actual premiums paid by the individual on a plan purchased on an exchange, or (ii) the community-rated premiums for the second-cheapest "silver" plan offered through an exchange for the geographic "rating area" where the individual resides. *Id.* §§ 36B(b)(2), (b)(3)(C).

The CBO has predicted that, by 2019, 24 million people will be insured through exchanges, and 20 million of them will receive federal subsidies of, on average, $6,460 per person.[26] That amounts to an annual federal subsidy of almost $13 billion.

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[26] CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010*, at 19 (Mar. 30, 2011) ("CBO, *Analysis*"), http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.

4. Employer "Responsibility" Assessment

Subtitle F of Title I imposes "Shared Responsibility for Health Care," not just on individuals subject to the mandate, but on employers as well. Immediately after creating the mandate requiring "Individual Responsibility" for insurance in Part I, Subtitle F creates "Employer Responsibilities" in Part II. In contrast to the individual mandate, employers' "responsibility" does not include a direct legal requirement to offer insurance to their employees. Instead, it consists of an exaction that is triggered if at least one employee of an employer with at least 50 full-time employees obtains a federal subsidy to purchase health insurance on an exchange, whether because (a) the employer fails to offer "minimum essential coverage" in an employer-sponsored plan, 26 U.S.C.A. § 4980H(a), or (b) the employer offers "minimum essential coverage," but it is unaffordable or does not cover the same level of benefits as a "bronze" plan on an exchange, *id.* § 4980H(b). *See also* Pet.App. 45a-47a.

5. Expansion Of Medicaid

In keeping with the Act's theme of "shared responsibility," Title II compels the States to expand Medicaid coverage for many individuals who would likely not be able to obtain other insurance. Starting in 2014, states must offer Medicaid to adults under age 65 with incomes up to 133% of federal poverty levels. 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII). States must likewise offer Medicaid to all children whose families earn up to 133% of federal poverty levels. *Id.* §§ 1396a(a)(10)(A)(i)(VII), 1396a(l)(1)(D), 2(C). As the Eleventh Circuit explained, "[t]his is a significant change, because previously the Medicaid Act did not set a baseline income level [and] many states currently do not provide Medicaid to childless adults and cover parents only at much lower income levels." Pet.App. 49a.

6. Revenue-Raising And Deficit-Neutrality "Offset" Measures

To ensure a CBO score of deficit-neutrality, the Act includes various tax increases and spending cuts necessary to fund the subsidies, Medicaid expansion, and other expenditures in the Act. As the Federal Government itself explained below, "[w]hen Congress passed the ACA, it was careful to ensure that any increased spending ... was offset by other revenue-raising and cost-saving provisions." RE 1024.

Title IX adopts a series of new healthcare-related taxes and fees expressly described as "Revenue Offset Provisions," which fall, *inter alia*, on individuals, employers, insurance companies, pharmaceutical companies, and manufacturers of medical devices. *E.g.*, 26 U.S.C.A. §§ 1401(b)(2), 1411, 3101(b)(2) (imposing additional Medicare taxes on high-income taxpayers); *id.* § 4980I (taxing so-called "Cadillac" plans); *id.* §§ 106(f), 125(i), 220(d)(2)(A), 223(d)(2)(A) (restricting ability to pay for healthcare with pre-tax dollars); *id.* § 213(a) (limiting itemized deduction for medical expenses); *id.* § 139A (eliminating deduction for employers who provide prescription-drug coverage for retirees); ACA §§ 9008-9010 (various fees).

The Act also cuts various payments under public programs such as Medicare. For example, it reduces "disproportionate share hospital payments," which are special payments to hospitals that provide a disproportionate share of uncompensated care. 42

U.S.C.A. §§ 1396r–4(f)(7), 1395ww(r). According to the President, this was a "common-sense change[]" because "if more Americans are insured, we can cut payments that help hospitals treat patients without health insurance." Sheryl Gay Stolberg & Robert Pear, *Health Plan May Mean Payment Cuts*, N.Y. TIMES, June 14, 2009, at A20.

7. Miscellaneous Additions

The Act also includes hundreds of measures ostensibly aimed at improving the quality, efficiency, and availability of healthcare. Many of these operate through public programs like Medicare. *E.g.*, ACA §§ 2501, 2503 (adjusting reimbursement formulas for prescription drugs); *id.* § 3401 (adjusting payments for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers according to productivity); 42 U.S.C.A. § 1395ww(q) (reducing Medicare payments to hospitals with specified percentages of preventable readmissions); *id.* § 1395ww(p) (reducing Medicare payments for hospital-acquired conditions).

Other measures involve direct federal spending. *E.g.*, 42 U.S.C.A. § 1315a (creating Center for Medicare and Medicaid Innovation to study more efficient payment methods for public programs); *id.* § 300hh–31 (establishing grants for epidemiology laboratories); *id.* § 1320e (establishing "Patient-Centered Outcomes Research Institute" to research effectiveness of various medical treatments).

And yet other provisions impose direct requirements on employers or individuals. *E.g.*, 29 U.S.C.A. § 207(r)(1) (requiring employers to provide reasonable break times for nursing mothers); 21 U.S.C.A. § 343(q)(5)(H) (requiring chain restaurants to "disclose in a clear and conspicuous manner" the nutritional content of standard menu items).

Many provisions of the Act, though not directly related to the individual mandate or the insurance regulations, were added as *quid pro quo* measures needed to secure the votes of specific legislators. For example, legislators such as Congressman Bart Stupak and Senator Ben Nelson insisted that the bill clearly prohibit the use of federal funds to pay for abortions. *See* ACA § 1303; David D. Kirkpatrick, *Abortion Fight Adds to Debate on Health Care*, N.Y. TIMES, Sept. 29, 2009, at A1. Other provisions in the Act were, even more explicitly, included to benefit individual legislators. For example, § 10323 of the Act extends Medicare coverage to "individuals exposed to environmental health hazards" in an area "subject to an emergency declaration made as of June 17, 2009." In fact, this "cryptic, mysterious" provision, demanded by Montana Senator Max Baucus, refers specifically to "people exposed to asbestos from a vermiculite mine in Libby, Montana." Robert Pear, *Buried in Health Bill, Very Specific Beneficiaries*, N.Y. TIMES, Dec. 21, 2009, at A1. Likewise, § 2006 increases Medicaid payments to certain "states recovering from a major disaster." In fact, this would give hundreds of millions of dollars to a single state, Louisiana, and was inserted at the behest of wavering Louisiana Senator Mary Landrieu. Brian Montopoli, *Tallying the Health Care Bill's Giveaways*, CBS NEWS, Dec. 21, 2009.[27]

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[27] http://www.cbsnews.com/8301-503544_162-6006838-503544.html.

Still other provisions were not identified as part of specific *quid pro quos*, but provide suspiciously targeted benefits. For example, § 10502 of the Act grants $100 million to an unnamed "health care facility" affiliated with a health center at a public university in a state where there is only one public medical and dental school. *Buried in Health Bill, Very Specific Beneficiaries*, *supra* ("Senators and their aides ... were not sure who would qualify for this money ... [but] a new school in Scranton, Pa., was a likely candidate."); *see also Tallying the Health Care Bill's Giveaways*, *supra* ("Also in the bill ... is an item that increases Medicare payments to hospitals and doctors in states where half the counties are 'frontier counties' .... Montana, North Dakota, South Dakota, Utah and Wyoming.").

The Senate Majority Leader, one of the chief architects of the legislative deal, candidly admitted doubting "if there's a senator that doesn't have something in this bill that was important to them."[28]

C. Private Petitioners' Challenge

Private Petitioners NFIB, Ahlburg, and Brown, along with 26 States, brought this action challenging the ACA's facial validity. Pet.App. 2a. As relevant here, they argued that the individual mandate exceeds Congress' Article I authority and cannot be severed from the remainder of the Act. *Id.* 3a.

The district court granted summary judgment to the challengers. Holding the mandate to be unconstitutional and non-severable, the court invalidated the Act in its entirety. *Id.* 362a-364a The Eleventh Circuit affirmed in part and reversed in part. In an opinion jointly authored by Chief Judge Dubina and Judge Hull, that court held the mandate unconstitutional, but concluded that it was severable from the remainder of the Act, including even the insurance regulations that the Government had *conceded* were non-severable. *Id.* 186a & n.144.

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[28] David Welna, *On Health Bill, Reid Proves The Ultimate Deal Maker*, National Public Radio, Dec. 23, 2009, http://www.npr.org/templates/story/story.php?storyId=121791736.

After the parties filed their certiorari petitions, Petitioner Brown, whose standing had been conceded by the Government in the Eleventh Circuit (*id.* 8a), filed a voluntary petition for bankruptcy. *See* Letter from G. Katsas to D. McNerney (Dec. 7, 2011). Private Petitioners do not believe that Brown's pending bankruptcy undermines her standing; to the contrary, her worsened financial state exacerbates the degree to which future costs from the mandate are "immediately and directly affect[ing]" her "financial strength[] and fiscal planning." *Clinton v. City of New York*, 524 U.S. 417, 431 (1998). Moreover, Brown's standing obviously does not affect the standing of Petitioners Ahlburg or NFIB, both of whom the courts below held had standing: Ahlburg is an unrelated individual, and NFIB has additional members who filed declarations materially indistinguishable from Brown's in support of NFIB's associational standing. *See* Pet.App. 8a-10a, 290a-293a, 439a; JA 151-56. Nevertheless, in an abundance of caution, on January 4, 2011, Private Petitioners, with the support of the Government and the State Petitioners, moved to add two of these additional NFIB members as formal parties, thereby eliminating any possible concerns. That motion is pending as of this filing.

SUMMARY OF ARGUMENT

Severability of an unconstitutional statute turns on congressional intent. By any fair measure, the text, structure, and operation of the ACA—not to mention its tortured path through the legislative process—make it evident that, without the individual mandate at its heart, no statute remotely resembling the Act would or could have been enacted. Once the mandate is invalidated, the entire Act must fall with it.

In constructing the ACA, Congress sought to restructure the health-insurance market to obtain near-universal coverage, bring down costs, and keep the federal deficit from growing. Ambitious goals, but Congress believed it had a magic bullet to achieve them—the individual mandate. By forcing healthy individuals to buy full-scale insurance at artificially inflated prices, the mandate handed an annual $30 billion subsidy to insurance companies. That subsidy allowed Congress to force the insurers, in turn, to sell coverage to the old and the sick at artificially low prices. The Federal Government could then provide limited assistance to those who could not afford even the premiums as reduced by the mandate's subsidy. Miscellaneous taxes and spending cuts could balance out this new spending and thus maintain deficit-neutrality. And, with individuals and insurance companies bearing such a substantial amount of the Act's costs, employers and States could be co-opted into filling some residual gaps—by, respectively, sponsoring affordable insurance for employees and expanding public-insurance programs like Medicaid.

Without the mandate, the remainder of the Act cannot operate as Congress intended. Absent the mandate's mammoth subsidy to insurance companies, the Act's insurance regulations would dramatically drive up premiums—reversing Congress' goal of reducing health-insurance costs. That is why Congress found the mandate "essential" to these provisions, and why the Government concedes that at least some of them cannot survive alone. But without the mandate *and* the new regulations prohibiting the insurance practices that Congress condemned as abusive and discriminatory, *none* of the Act's primary goals would be satisfied. These provisions are the heart of the Act, its central *raison d'etre*. To remove them would be to fundamentally alter the legislation; this Court has *never* used severability to effect such a major change to such a major part of such a major bill.

Moreover, without the mandate and insurance regulations, none of the Act's major planks would operate as intended by Congress. Federal subsidies would no longer be linked to community-rated premiums; instead, they would *pay* private insurance companies for the very "abusive" practices Congress intended to *forbid*. Other actors, like healthcare providers and the States, would bear burdens well beyond those intended, as elimination of the mandate and insurance regulations would destroy the bill's careful allocation of shared responsibility. And new taxes would reap revenue no longer being used to further the Act's primary goals. At best, the parts of the Act unaffected in operation by the foregoing measures would amount to a hodge-podge of minor, miscellaneous measures, many added only to secure passage of provisions no longer intact.

That is nothing like what Congress enacted, and it is not an Act that Congress would have enacted. The ACA was the fragile product of extensive legislative deal-making; to strip out its centerpiece would fundamentally alter the original legislative bargain. Particularly in light of the *deletion* of a severability clause from an earlier version of the bill, and the House's determination to consider the Act on an all-or-nothing basis, it is clear that Congress intended this unique legislative deal to rise or fall as a whole. Invalidation of the mandate therefore requires that the entire Act be stricken; this Court should leave to Congress the complex and political task of revisiting comprehensive health-insurance reform.

ARGUMENT

I. UNCONSTITUTIONAL PROVISIONS MAY BE SEVERED ONLY WHERE CONSISTENT WITH CONGRESSIONAL INTENT

When a court invalidates part of a statute, it faces the question of what happens to the rest. Can the stricken provision be severed, so that the remainder of the statute survives? Or would severance—the slicing of legislation into a new, judicial creation—be an inappropriate intrusion into the lawmaking process? The answer, as this Court has explained, depends on legislative intent: whether Congress would have enacted the bill absent the stricken provision, or whether omission of that provision would have scuttled legislative bargains or undermined statutory objectives. If the latter is true, judicial revision through severance is improper, particularly where it entails complex line-drawing that is best left to the legislature.

Severability questions invariably raise serious separation-of-powers issues. By severing invalid provisions, courts may save Congress from having to go back to the drawing board. On the other hand, severance creates a law that Congress never enacted, and risks having it operate differently than intended—*e.g.*, by preserving a *quid* enacted only because of the now-invalidated *quo.* Such partial invalidation of integrated statutes thus may produce a serious invasion of the legislative domain. To respect the distinct legislative and judicial roles, severability analysis must recognize the separation-of-powers concerns on *both* sides of the calculus.

A. An Unconstitutional Provision Cannot Be Severed If The Remainder Of The Act Would Not Operate As Congress Intended, And So Would Not Have Been Enacted On Its Own

"The inquiry into whether a statute is severable is essentially an inquiry into legislative intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999); *see also Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006) ("[T]he touchstone for any decision about remedy is legislative intent."). The ultimate question is whether Congress "would have been satisfied with what remained" after the unconstitutional provisions were removed. *Champlin Rfg. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 235 (1932). Courts should avoid "nullify[ing] more of a legislature's work than is necessary," *Ayotte*, 546 U.S. at 330, but it would likewise be improper for judges to "substitute, for the law intended by the legislature, one they may never have been willing by itself to enact," *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 636 (1895).

If "the balance of the legislation is incapable of functioning independently," then certainly "Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987). But even if the remainder of the act could stand alone from an operational perspective, the question remains whether "it is evident that the Legislature would not have enacted those provisions independently of that which is invalid." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) ("*FEF*"). Thus, "[t]he more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685.

To determine whether the rest of the legislation would operate in the "manner" intended by Congress, courts look to various objective factors, including: "the nature" of the stricken provision, *Alaska Airlines*, 480 U.S. at 685; its role "in the original legislative bargain," *id.*; the "historical context" of the legislation, *FEF*, 130 S. Ct. at 3162; the economic connection between the invalidated provision and the remainder of the statute, *Carter v. Carter Coal Co.*, 298 U.S. 238, 314-15 (1936); and the impact of that provision on the "dominant aim of the whole statute," *R.R. Ret. Bd. v. Alton R.R. Co.*, 295 U.S. 330, 362 (1935). If these considerations show that Congress "would not have been satisfied with what remains" after invalidation of the unconstitutional provision, then severance is improper. *Williams v. Standard Oil Co.*, 278 U.S. 235, 242 (1929).

In undertaking the analysis, courts consider clauses that expressly address severability—text that apprises the judiciary whether Congress intends the statute's provisions to survive, and to operate independently of, any one that may be invalid. Thus, inclusion of a severability clause "gives rise to a presumption that Congress did not intend the validity of the Act as a whole, or of any part of the Act, to depend upon whether" a particular provision "was invalid." *INS v. Chadha*, 462 U.S. 919, 932 (1983). But the absence of a severability clause is treated simply as silence, creating no presumption at all, neither "against severability," *Alaska Airlines*, 480 U.S. at 686, nor for it, *see* Br. of Amici Curiae Family Research Council et al. at 4-14 (Nos. 11-393 & 11-400). If, however, a severability clause was specifically *removed* from a law during the legislative process, that "does suggest that Congress intended to have the various components of the [legislative] package operate together or not at all." *Gubiensio-Ortiz v. Kanahele*, 857 F.2d 1245, 1267 (9th Cir. 1988) (Kozinski, J.); *accord United States v. Croxford*, 324 F. Supp. 2d 1230, 1245 (D. Utah 2004) (Cassell, J.); *see also Russello v. United States*, 464 U.S. 16, 23-24 (1983) (drawing inference of congressional intent from fact that Congress included text "in an earlier version of a bill but delete[d] it prior to enactment").

B. Severability Analysis Must Account For The Separation-Of-Powers Dangers Inherent In Both Potential Courses of Action

This Court has observed that the refusal to sever unconstitutional provisions "frustrat[es] the intent of the elected representatives of the people." *Regan v.*

Time, Inc., 468 U.S. 641, 652 (1984) (plurality opinion). Accordingly, courts should "act cautiously" and "refrain from invalidating more of the statute than is necessary." *Id.* Conversely, however, if the Court does sever part of a statute, the necessary result is a new law that was never enacted by the political branches through the required means of bicameral passage and presentment to the President, *Chadha*, 462 U.S. at 951-59. Judicial creation of such new laws poses obvious dangers of intrusion into legislative function: "This would, to some extent, substitute the judicial for the legislative department of the [G]overnment," and in substance "make a new law, not ... enforce an old one." *United States v. Reese*, 92 U.S. 214, 221 (1876). Indeed such partial invalidation "may call for a 'far more serious invasion of the legislative domain' than [the Court] ought to undertake," especially "where linedrawing [would be] inherently complex." *Ayotte*, 546 U.S. at 330 (quoting *United States v. Nat'l Treasury Employees Union*, 513 U.S. 454, 479, n.26 (1996)).

The Court has therefore repeatedly held it improper to rewrite a statute to solve constitutional flaws. To "dissect an unconstitutional measure and reframe a valid one," by "inserting limitations it does not contain," would be "legislative work beyond the power and function of the court." *Hill v. Wallace*, 259 U.S. 44, 70 (1922); *see also FEF*, 130 S. Ct. at 3162 (courts lack "editorial discretion" to "blue-pencil" statute). Given the "many different possible ways the legislature might respond" to the law's defects, courts should let *Congress* "rewrite those provisions." *Randall v. Sorrell*, 548 U.S. 230, 262 (2006).

Partial judicial deletion of an enacted statute can pose similar problems of judicial usurpation. As this Court noted in holding that Congress cannot authorize the President to delete parts of an enacted statute, selective deletion impermissibly amends an enacted law: "In both legal and practical effect, the President has amended two Acts of Congress by repealing a portion of each." *Clinton*, 524 U.S. at 438; *cf. Hill*, 259 U.S. at 71 (reiterating that severability "does not give the court power to amend the act"). Moreover, partial judicial "repeal" leaves in its wake a never-enacted law based on judicial speculation about counter-factual congressional desires. Particularly when Congress has omitted a severability clause—the traditional method of informing courts how it wants the judiciary to respond if part of a law is held unconstitutional—there is a grave danger that excising only part of the integrated whole will be based on mere guesswork, which may result in judicial creation of a law that Congress would not have enacted.

Indeed, such selective judicial deletion is virtually indistinguishable from improper judicial revision where the "line-drawing is inherently complex," *Ayotte*, 546 U.S. at 330. This is especially true here because, as discussed below and as even the Government concedes, *some* constitutional parts of the Act *must* be excised once the mandate is invalidated. When some constitutional parts of a law must be severed, judicial selection of *which* parts of Congress' permissible handiwork will remain is akin to judicial rewriting. *Selectively* deleting the remaining parts of the statute entails the same "blue pencil[ing]" as judicial rewriting. In both cases, the Court is not performing the straightforward judicial function of striking unconstitutional statutory provisions, but also the quasi-legislative function of deciding which lawful provisions will survive, based on guesswork about which subset of the constitutional residue best serves Congress' policy goals.

Finally, these worries of judicial intrusion on legislative prerogative are particularly acute when the invalidated provision is part of a comprehensive, heavily negotiated package. Where legislation is born of compromise, severing an invalid provision threatens improperly to strip one side of the deal of its benefits in the "original legislative bargain." *Alaska Airlines*, 480 U.S. at 685. *See, e.g.*, *Carter*, 298 U.S. at 316 (refusing to sever provisions that are "conditions, considerations, or compensations" for one another); *Allen v. Louisiana*, 103 U.S. 80, 84 (1881) (same); *see also Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 561-62 (2001) (Scalia, J., dissenting) (courts have "no authority" to "eliminate a significant *quid pro quo* of the legislative compromise"). It is no answer to say that Congress can simply repeal the remainder, given the inertial forces that check the legislative process. Imagine, for example, a law including some provisions demanded by each house of Congress, together reflecting a *quid pro quo*. If a court were to invalidate only one set of these, the result would be a law that never would have been enacted yet is unlikely to be repealed. Further, in a comprehensive legislative package, removal of any provision could impact the severability of every *other* provision, making the task all the more difficult and all the less appropriate for the judiciary.

The lesson is that this Court, "mindful that [its] constitutional mandate and institutional competence are limited," *Ayotte*, 546 U.S. at 329, must be equally skeptical of severing either too much *or too little* of a law. At least absent a severability clause, severing a key provision from a hard-fought legislative deal should be viewed with special skepticism.

II. THE ACT'S INSURANCE REGULATIONS OPERATE IN TANDEM WITH, AND SO MUST FALL WITH, THE INDIVIDUAL MANDATE

The Act expressly states that the mandate is "essential to creating effective health insurance markets" because it was necessary to "lower health insurance premiums" that would be increased by the guaranteed-issue and community-rating provisions. 42 U.S.C.A. § 18091(a)(2)(I). That statutory finding—expressly linking the intended operation of the guaranteed-issue and community-rating provisions to the mandate—should be dispositive for severability purposes. But, in any event, further examination of the interrelationship of these provisions eliminates any conceivable doubt.

Even the Government agrees that the individual mandate is inextricably linked to the guaranteed-issue and community-rating requirements. The mandate was intended to be a direct subsidy to insurance companies, as compensation for requiring them (in the guaranteed-issue provision) to insure against "risks" that have already come to pass and forbidding them (in the community-rating provision) from using actuarially sound insurance premiums. The mandate thus works to counteract the powerful inflationary impacts of these other provisions, which would otherwise make premiums in the individual insurance market prohibitively expensive, thereby frustrating Congress' goal of affordable health insurance. And Congress further viewed the mandate as necessary to prevent "adverse selection" to "game" the new insurance rules, which proponents warned would spark a "death spiral" in insurance.

The guaranteed-issue and community-rating requirements thus cannot operate without the mandate in the manner intended by Congress. Rather, "their associated force—not one or the other but both combined—was deemed by Congress to be necessary to achieve the end sought." *Carter*, 298 U.S. at 314. To strike the mandate alone would impermissibly eliminate a central *quid pro quo* of the Act. If the mandate falls, the guaranteed-issue and community-rating regulations must therefore fall with it, as the Government itself has conceded.

A. Congress Intended The Individual Mandate To Offset The New Burdens Imposed On Insurers By The Act's Insurance Regulations

The Act's guaranteed-issue and community-rating rules, both found in Subtitle C of Title I, prohibit the related "discriminatory" practices of denying coverage for a pre-existing condition or charging higher premiums to people who will require greater health-care expenditures because of risky conditions or habits. *Supra* at 10-11.

As Congress recognized, the unavoidable result of these measures would be a dramatic rise in premiums. The CBO estimated that they would cause a 30% increase in individual premiums. *Supra* at 11. Congress also believed that, because insurance companies would now be prohibited from "discriminating" against sick people, "many individuals would wait to purchase health insurance until they needed care." If the prediction of this type of "adverse selection" were accurate, it would reduce insurers' revenues, and thus force them to increase the premiums charged to their diminishing number of customers. *Supra* at 15.

Congress was equally explicit that the individual mandate was its solution to these dual problems created by the guaranteed-issue and community-rating provisions. As the statutory findings expressly state, Congress believed the mandate was "essential" to mitigating increased premiums from these effects, and thus to "creating effective health insurance markets." 42 U.S.C.A. § 18091(a)(2)(I). This was so for two reasons.

First, the individual mandate's principal purpose and effect was to greatly offset the estimated 30% increase in premiums attributable to guaranteed-issue and community-rating. Specifically, the mandate was supposed to lower insurance premiums by 15-20%, or $28 to $39 billion annually, thus reducing nearly two-thirds of the premium increases caused by these insurance regulations. *Supra* at 14. It would do so by, in Congress' words, "add[ing] millions of new consumers to the health insurance market," 42 U.S.C.A. § 18091(a)(2), primarily healthy individuals whose premium payments far outweigh any reasonably foreseeable healthcare expenditures. This is why Congress emphasized that the individual mandate's "broaden[ing] [of] the health insurance risk pool to include *healthy* individuals" would "lower health insurance premiums." *Id.* (emphasis added).

A statute expected to increase premiums by some 30% would not have been acceptable to Congress, as it would have materially undermined the Act's stated goal of reducing costs to achieve "affordable care." The guaranteed-issue and community-rating rules would still dramatically drive up premiums, but without any countervailing effect. Absent the mandate, then, these insurance regulations plainly would not "function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. They are legislation that Congress "never [would] have been willing by itself to enact." *Pollock*, 158 U.S. at 636. Nor could Congress have, without the vital support of the insurance industry, which found the insurance requirements palatable only as tempered by the mandate. *See supra* at 2, 12.

In short, the mandate is so closely tied to these provisions that its invalidation spells their demise. In concluding otherwise, the Eleventh Circuit simply failed to consider the adverse effect on premiums—and thus on the Act's express purposes—that the insurance regulations would have, if unmitigated by the mandate. *See* Pet.App. 180a-85a.

Second, Congress expressly stated its belief that the individual mandate was "essential" to eliminate the "adverse selection" enabled by guaranteed-issue and community-rating. 42 U.S.C.A. § 18091(a)(2)(I). To be sure, as the Eleventh Circuit explained, Congress greatly exaggerated this problem. *See supra* at 15, n18. Nevertheless, second-guessing Congress' judgments about how the individual mandate will actually operate should play no role in severability analysis. For severability, the question is whether *Congress* "would ... have been satisfied with what remains" after the unconstitutional provision is invalidated, *Williams*, 278 U.S. at 242, not whether Congress *should* have been satisfied had it better understood the effect of its law.

In sum, because Congress thought the individual mandate was "essential" to cure dramatic premium increases and market distortions caused by the guaranteed-issue and community-ratings provisions, those provisions cannot, without the mandate, "function in the manner" Congress intended.

B. The Act's Guaranteed-Issue And Community-Rating Provisions Are Indistinguishable From Its Other, Related Insurance Regulations

The Government has acknowledged that the mandate cannot be severed from the guaranteed-issue and community-rating provisions. Govt. Cert. Resp. 31-33 & n.13. But these provisions cannot be singled out from the Act's restrictions on health-insurance products. *All* of these regulations, which appear together in Sections 1001 and 1201 of Title I of the Act, also must fall with the mandate—and for the same reasons.

In addition to precluding insurers from setting premiums based on individualized factors, and from refusing to cover pre-existing conditions, the Act imposes closely related restrictions on insurance products. Many are designed to combat the *same* assertedly abusive or unfair insurance practices addressed by the guaranteed-issue and community-rating rules. For example, the Act forbids insurers to set limits on coverage, to exceed certain levels of cost-sharing, to refuse to cover various services, or to freely rescind or decline to renew coverage. *Supra* at

10-11. Like the guaranteed-issue and community-rating provisions, all of these are designed to protect health-insurance consumers—particularly unhealthy consumers most in need of open-ended, permanent coverage—from insurance practices that make coverage inadequate, expensive, or unavailable. By forcing insurers to offer policies on economically unfavorable terms, all of these provisions would drive up premiums. The individual mandate would offset many of those increased costs. The insurance regulations, together, thus comprise a package of restrictions that work in unison and are offset by the mandate. Absent the mandate, the *entire* set of insurance regulations must be invalidated.

The Government's position, that this Court can strike the guaranteed-issue and community-rating provisions, but nonetheless retain the other insurance regulations, seems to rest on a policy determination that eliminating the former provisions, but no others, would sufficiently relax the burdens on insurance companies to make up for invalidation of the mandate's subsidy. But that is precisely the type of responsive policy choice reserved to Congress. *See, e.g.*, *Randall*, 548 U.S. at 262. For example, Congress could just as easily have decided to remedy the problem by retaining guaranteed-issue and community-rating but doing without the prohibition on coverage limits. For this Court to choose *which* of the Act's insurance regulations to strike, in an effort to offset the effects of invalidating the mandate, would amount to nothing less than unauthorized "blue pencil[ing]" of the Act, *FEF*, 130 S. Ct. at 3162.

III. WITHOUT THE MANDATE AND INSURANCE REGULATIONS AT ITS HEART, THE ACT WOULD NOT OPERATE AS CONGRESS INTENDED

It is one thing to strike, from a major law, a minor or ancillary provision only tangentially related to its overarching purposes. But it is another thing entirely to displace a primary pillar of the legislative structure. When legislation is constructed around certain foundational provisions, striking them will almost inevitably topple the edifice as a whole.

The Act's pillars are the insurance regulations and the individual mandate. Indeed, the Act's full name is the *Patient Protection* and *Affordable Care* Act. By forcing insurance companies to forever extend equally priced coverage to all comers, the Act "protects patients" from market practices thought to be discriminatory. By forcing unwilling Americans to purchase insurance, the law subsidizes everyone else's premiums, ensuring "affordable care." These provisions are the heart of the legislation, and the foundation of the statute. None of the Act's other provisions can survive their excision; Congress would hardly have reached the same destination had it proceeded from an entirely different starting point.

Moreover, without the mandate and insurance regulations, the Act's other principal features would operate in dramatically different ways, shifting costs in unforeseen directions and allocating benefits and burdens inconsistent with the congressional scheme. Some of these provisions could perhaps continue to "function" without the mandate and insurance regulations, but not "in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685.

A. The Mandate And Insurance Regulations Are So Central To The Act's Principal Objectives That The Entire Act Must Be Invalidated

1. In determining whether partial invalidation would produce "legislation that Congress would not have enacted," *Alaska Airlines*, 480 U.S. at 685, courts consider "the nature" of the stricken provision; its role "in the original legislative bargain," *id.*; and the "historical context" of the legislation, *FEF*, 130 S. Ct. at 3162. These considerations establish a basic divide between run-of-the-mill provisions and legislative centerpieces. A statutory provision will likely be severable if it played only a minor role in the legislative debate; or if its effects are relatively small in the grand scheme; or if it simply added an additional frill to an otherwise-coherent regime. Conversely, if a provision was especially contentious; or if it constituted a core element of the legislation; or if it was a principal means of securing the law's objects, severing it would likely be improper.

The caselaw bears out this distinction. For example, in *Alaska Airlines*, the record showed that Congress had "paid scant attention" to the unconstitutional provision of the statute at issue, while it had regarded another provision as "an important feature." 480 U.S. at 691. During floor debate, "neither supporters nor opponents of the bill ever mentioned" the unconstitutional provision; it was, in fact, mentioned but once "during the entire deliberation on the Act"—and even then, only in general terms. *Id.* at 691-96. Faced with this history, the Court could not conclude that Congress "would have failed to enact" the law "if the [invalid provision] had not been included." *Id.* at 697.

Similarly, in *Reagan v. Farmers' Loan & Trust Co.*, 154 U.S. 362 (1894), the invalidation of a provision giving conclusive effect to railroad rates set by an agency did not require striking the entire statute, which created the agency and gave it regulatory authority. Rather, "creation of a commission, with power to establish rules for the operation of railroads and to regulate rates, was the *prime object* of the legislation," and that object could be "*fully accomplished*" regardless of "whether the rates shall be conclusive or simply *prima facie* evidence." *Id.* at 395-96 (emphases added); *see also United States v. Jackson*, 390 U.S. 570, 586-91 (1968) (invalidating death-penalty provision but severing it from criminal prohibition, as "elimination [of death penalty] in no way alters the substantive reach of the statute and leaves completely unchanged its basic operation").

By contrast, in *Mille Lacs Band*, the Court considered an executive order that (i) directed certain Indians to remove from territories they had ceded to the United States; and (ii) stripped those Indians of their treaty rights to hunt and fish on those lands. 526 U.S. at 179. After invalidating the former aspect of the order, the Court held it was not severable from the latter. Applying the "severability standard for statutes," the Court concluded that the order had "to stand or fall as a whole," because it "embodied a single, coherent policy," and removal of the Indians from the lands was its "predominant purpose." *Id.* at 191. Although the other portion of the order admittedly "perform[ed] an integral function in this policy," it could not survive on its own after the primary function of the executive order had been so undermined. *Id.* at 192.

The severability principles applied in *Mille Lacs Band* have been settled for decades. For example, in *Alton*, the invalidation of central features of a compulsory pension scheme required the entire statute to be scrapped, because the unconstitutional provisions "so affect[ed] the dominant aim of the whole statute as to carry it down with them." 295 U.S. at 361-62. Likewise, in *Williams*, this Court invalidated the substantive provisions of price-fixing legislation, 278 U.S. at 239-41, and then held that the law's other provisions could not stand alone because they were "mere appendants in aid of the [statute's] main purpose" or "mere aids to their effective execution." *Id.* at 243-44. Although the new agency designated to fix prices could, in theory, still collect data, issue permits, and collect fees, it would have been "unreasonable to suppose" that the legislature would have wanted these mechanisms to keep operating once the most basic function of the law had been disabled. *Id.* at 244.

These cases make clear that severance is improper when the stricken provision is the heart of the legislative scheme—the principal effort toward its predominant purpose. In that context, it cannot fairly be surmised that Congress would have pushed ahead unperturbed, making no changes to the bill once its hallmark was stripped out. In such cases, the residue simply could not function in the manner that Congress intended. And it is not enough that Congress might have enacted "*some* form" of legislation without the invalid provision; severance is permissible only if Congress would have enacted "the same [provisions] currently found in the Act." *Alaska Airlines*, 480 U.S. at 685 n.7.

2. The individual mandate, together with the insurance reforms, are the heart of the ACA, as demonstrated by their crucial significance in achieving its objectives and their central role in the legislative debate. The ACA cannot survive the elimination of these critically important provisions.

The overriding goals of the Act were to reduce premiums and the number of uninsured, without raising the deficit. *Supra* at 2-6; 42 U.S.C.A. § 18091(a)(2)(F). It is no surprise, then, that both the mandate and the insurance regulations appear in the Act's first title. These were considered indispensable to meeting the Act's core objectives. To expand coverage, the insurance regulations force insurers to provide coverage to the unhealthy on terms economically *unfavorable* to insurers. To keep premiums down, the mandate forces healthy people to buy insurance on terms economically *favorable* to insurers. And Congress thereby avoided the need to use direct spending to subsidize insurance companies (as well as the concomitant need to adopt a politically unpopular tax). The insurance regulations fundamentally transform the way health insurance may be sold in this country, and the mandate is expected to force some 16 million new consumers into the insurance market. By any fair measure, these provisions are the Act's centerpiece, and embody its "predominant purposes" or "dominant aims." Accordingly, once they are invalidated, the rest of the Act must fall. This is true even if its other parts can operate independently: Hunting and fishing rights in *Mille Lacs Band*, for example, could have been stripped independent of tribal removal, but because the latter was the "predominant purpose" of the executive order, its invalidity doomed the whole.

Further confirming this point, the mandate and insurance regulations were the clear focus of the debate surrounding the Act's negotiation and enactment. The President's 2010 State of the Union address, delivered while the Act was being debated in Congress, highlighted his desire to "protect every American from the worst practices of the insurance industry"—through the insurance regulations—and to give "uninsured Americans a chance to choose an *affordable* health care plan in a competitive market"—through the mandate. *Supra* at 3. Legislators emphasized that the insurance reforms would rein in practices condemned as odious and discriminatory. *Supra* at 4. Indeed, a major voting bloc was committed to going still further—through a public option designed to entirely eliminate the "profit motive" in insurance—but settled for the insurance regulations as a necessary compromise. *See supra* at 5-6. And numerous legislators highlighted how the mandate, together with guaranteed-issue and community-rating, would decrease the number of uninsured individuals in the country. *Supra* at 4-5; 42 U.S.C.A. § 18091(a)(2)(C) (finding that mandate "will increase the number and share of Americans who are insured"). What matters is not the accuracy of these claims, but that the Act is largely premised on them.

The contrast to *Alaska Airlines*—where the invalid provision had been referenced only a single time during extensive debate, 480 U.S. at 691—could not be starker. Congress' sustained attention to the mandate and insurance reforms reflects their singular importance to the overall legislative bargain.

B. Invalidating Only The Mandate And Insurance Regulations Would Disturb The Allocation Of "Shared Responsibility" Intended By Congress

Analysis of the Act's other notable provisions reinforces that the mandate and insurance regulations were its foundational premises. Without them, the operation of the Act's other features would be significantly undermined. And, if an unconstitutional provision "is of such import that the other sections without it would cause results not contemplated or desired by the legislature, then the entire statute must be held inoperative." *Connolly v. Union Sewer Pipe Co.*, 184 U.S. 540, 565 (1902).

Most obviously, elimination of the mandate and insurance regulations would displace Congress' effort to allocate the costs of the Nation's health insurance. President Obama argued that "[i]mproving our health care system only works if everybody does their part." *Remarks to Congress*, *supra*. "Shared Responsibility for Health Care" (ACA Title I, Subtitle F) is thus the Act's theme; Congress sought to distribute the costs of near-universal coverage across individuals, employers, insurers, participants in the healthcare industry, States, and the Federal Government itself. As explained below, without the mandate and insurance regulations, individuals and insurers will be freed of the major burdens that the Act imposed on them—and other stakeholders will, to a degree not intended, be left to pick up the slack.

Pollock is instructive as to the implications of those redistributive impacts. In that case, this Court invalidated a general income tax as applied to income from real or personal property. 158 U.S. at

637. Then, it held that the tax could not survive subject to those exclusions, because revenues from property "formed a vital part of the scheme," and striking it "would leave the burden of the tax to be borne by professions, trades, employments, or vocations." *Id.* at 636-37. Eliminating the invalid provisions thus would shift tax burdens "in a direction which could not have been contemplated." *Id.* at 637. "[W]hat was intended as a tax on capital would remain in substance a tax on occupations and labor," and the scheme, "considered as a whole," was not intended to function as such. *Id.*

Here, striking only the mandate and insurance regulations would similarly disturb the allocation of costs and shared responsibility under the Act.

1. Title I of the Act includes not only the mandate and insurance regulations, but also subsidies to help individuals with lower incomes to buy insurance. The subsidies grant refundable tax credits tied to the lesser of (i) the premiums paid by those individuals, or (ii) the community-rated cost of the second-cheapest "silver" plan for the individual's geographic "rating area." *Supra* at 19-20.

If, per the Eleventh Circuit, this Court were to sever only the mandate, the anticipated cost to the Government would skyrocket. As explained above, in that circumstance, premiums in the individual market would rise by some 30%. *Supra* at 11. And, because the subsidies are calculated based on actual premium costs, the Government would be on the hook for these costs. Congress intended for the Government to subsidize premiums, but on the assumption that they would be relatively low, given the mandate's subsidy.

Even if the insurance regulations are properly invalidated along with the mandate, the subsidies would not operate as intended. The subsidy amounts are effectively capped by the community-rated premiums for the applicable geographic "rating area," *see* 26 U.S.C.A. § 36B(b)(3)(C); 42 U.S.C.A. § 300gg(a)(2), which of course exist only by virtue of the insurance regulations. And if that now-inoperative cap were simply set aside, and the subsidies calculated by reference only to actual premiums paid, the effects would be unacceptable: Absent the insurance regulations, insurers would return to the individualized pricing that Congress found discriminatory, with higher premiums for the elderly and those with pre-existing conditions. Yet the Government, paying subsidies tied to actual premiums, would simply be footing the bill for *private insurers* to charge these *unrestricted* prices. Rather than *ban* the insurer practices that Congress condemned, the Act would actually *pay for them* with federal money. The Congress that enacted the ACA could not possibly have intended that result.

Nor would Congress have been willing to pay the whole bill for universal coverage. Congress required healthy people, through the mandate, to provide an annual $30 billion subsidy to defray premiums for the sick—Congress simply could not afford, and never intended, for the Government to pay the entire amount. Moreover, if the Federal Government really wanted to shoulder the entire cost of healthcare for Americans who cannot afford it, it would likely have done so through a public program like Medicaid—not by simply accepting, and paying, "discriminatory" prices charged by private insurance companies.

2. A cousin to the individual mandate, the employer "responsibility" assessment, encourages certain employers to sponsor health plans for their employees. Specifically, it imposes an exaction on covered employers if one of their employees obtains a federal subsidy to help pay for insurance purchased elsewhere. *Supra* at 21.

This assessment—labeled "shared responsibility for employers regarding health coverage," 26 U.S.C.A. § 4980H—was one plank of a multi-part effort to spread health-care costs across *multiple* actors. For that reason alone, it cannot stand once individuals, insurers, and the Federal Government are all let off the hook. *Pollock*, 158 U.S. at 636-37.

Further, the exaction is inextricably intertwined with the subsidies described above. Indeed, if those subsidies are invalidated, no employee will ever receive one—and so the employer exaction will never be triggered. The employer exaction is thus simply "incapable of functioning independently" of the subsidies. *Alaska Airlines*, 480 U.S. at 684.

3. The Act also creates new health-insurance "exchanges," marketplaces where individuals and small businesses can buy the Act's new insurance products. The Federal Government only subsidizes coverage purchased within an exchange, thus giving insurance companies a reason to sell there despite the distinct regulatory burdens imposed on plans offered through the exchanges. *Supra* at 19-20.

The exchanges cannot be severed from the provisions already addressed. Without the subsidies driving demand within the exchanges, insurance companies would have absolutely no reason to offer their products through exchanges, where they are subject to far greater restrictions. Premised on the mandate, the insurance regulations, and the subsidies, the insurance exchanges cannot operate as intended by Congress absent those provisions.

4. Another part of the Act requires that States substantially relax the eligibility criteria for Medicaid. *Supra* at 21-22. But, as the Government explained below, Congress intended for the additional Medicaid spending required of the States to be "offset" by other "cost-saving provisions." RE 1024. For example, Congress believed the insurance regulations would prevent individuals with pre-existing conditions from being driven onto Medicaid rolls, or into state-funded high-risk pools, by the uninsurable cost of their care. *See* RE 1023; 42 U.S.C.A. § 18091(a)(2)(G) (finding that "62 percent of all personal bankruptcies are caused in part by medical expenses"). Congress further believed the States would also, in light of the mandate and premium subsidies, save money on uncompensated care. *See* RE 1023. If the States need no longer worry about picking up the tab for uninsurable sick people (because private insurers will now be forced to), or for cost-shifting by the uninsured (because the mandate will force them to buy insurance), then they can devote more resources to the poor. Absent the mandate, insurance regulations, and subsidies, this premise would no longer be true, and the States would be forced to bear additional costs far greater than those intended by Congress.[29]

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[29] Of course, if the Medicaid expansion is independently unconstitutional, as the State Petitioners contend, then the severability analysis must take their invalidity as a given.

5. Another major component of the Act is a set of new taxes, most of which are found in Subtitle A of Title IX ("Revenue Offset Provisions"), and a set of spending cuts to public programs like Medicare.

Many of these affect insurance companies and healthcare providers but, like the insurance regulations, were offset by the substantial benefits conferred by the mandate. *Supra* at 22. Without the mandate's subsidy, these taxes and cuts would saddle insurance companies and providers with far greater net burdens than did the original legislative bargain. *See Pollock*, 158 U.S. at 636-37.

Moreover, these provisions satisfied (as the heading of the revenue Subtitle indicates) the Act's overriding political constraint—that it not add to the federal deficit. *Supra* at 6. Given the new *liabilities* adopted by the Government—notably, the subsidies for low-income Americans—Congress had to include new *revenues* to "offset" them. The Act's revenue-raising and spending cuts were thus premised on the funds being used to expand coverage and hold down the cost of health insurance.

But, as shown, the subsidies cannot survive without the mandate and insurance regulations. And there is no reason to think that Congress would have imposed this hodge-podge of taxes and cuts for its own sake, without furthering the twin goals of the Act. Accordingly, these "offset" provisions, too, must fall. *Williams*, 278 U.S. at 244 (holding "taxes" that were enacted to "defra[y] the expenses" of an invalid provision to be non-severable). Nor could this Court restore budget neutrality by "blue pencil[ing]" the Act, *FEF*, 130 S. Ct. at 3162, in determining which of the new taxes to strike. *Randall*, 548 U.S. at 262.

* * *

In sum, Congress designed the Act to spread the costs of expanded insurance coverage among individuals (the mandate), insurers (the insurance regulations), employers (the "responsibility" assessment), the Federal Government (the premium subsidies), the States (the Medicaid expansion), and other actors (the "offset" taxes and spending cuts). Eliminating the mandate and insurance reforms would have major ripple effects, twisting Congress' reticulated scheme of "shared responsibility" beyond repair. Accordingly, the Act must be invalidated *in toto*.

C. Retaining Only The Act's Miscellaneous Tag-Along Provisions Would Fundamentally Change The Statute That Congress Enacted

To be sure, the discussion above does not address *every* provision of the 2700-page Act. As the Eleventh Circuit observed, within the law's countless provisions can be identified various obscure measures that appear independent of its major planks. The Act, for example, requires employers to provide "reasonable break time for nursing mothers" and restores "funding for abstinence education." Pet.App. 174a-175a. For three reasons, however, the existence of these peripheral provisions does not affect the conclusion of wholesale non-severability.

First, the mandate cannot be severed from the Act's *major* components. As explained above, a law's central pillars cannot be removed without toppling the statute as a whole, and the mandate and insurance regulations together plainly qualify as such pillars. *Supra* Part III.A. *A fortiori*, so too does the combination of the mandate, insurance regulations, subsidies, health exchanges, employer assessment, Medicaid expansion, and taxes. Once all of these are stricken, what is left would bear no resemblance to the statute Congress enacted.

Whereas severability analysis normally removes a small discrete part to preserve a larger coherent whole, the issue here is removing a large coherent whole to preserve small discrete parts. We are aware of no precedent that has allowed severance in remotely similar circumstances. And for good reason: It is inconceivable that Congress, trying to adopt a comprehensive solution to a perceived crisis, would "have been satisfied" with the menagerie of tag-along provisions that remain after a statute's pillars are removed. *Williams*, 278 U.S. at 242.

Second, if the severability analysis really must proceed provision-by-provision, courts would be faced with the impractical, unrealistic task of proceeding through the Act's "hundreds of new laws about hundreds of different areas of health insurance and health care," Pet.App. 21a, and evaluating each provision's relationship to the others and to the whole. There are simply too many provisions to engage in such granular inquiries, particularly because the severance of each provision could alter the calculus and call into question earlier decisions about other provisions. Once numerous, substantial pieces of the legislation cannot operate as intended, this Court should invalidate the whole statute.

Third, even if it were somehow practical to consider every provision on its own, the difficulty of analysis required would be far beyond the judicial ken. In an act this complex and interrelated, courts cannot confidently deem individual provisions to be operationally independent. Once a number of major provisions are stricken, the only responsible course for a court—"mindful that [its] constitutional mandate and institutional competence are limited," *Ayotte*, 546 U.S. at 329—is to declare the entire Act non-severable, and let Congress handle rebuilding.

IV. THE ACT WOULD NOT, AND COULD NOT, HAVE BEEN ENACTED WITHOUT THE MANDATE AND INSURANCE REGULATIONS

Another way of framing the severability inquiry is to ask whether the valid portions would have been enacted independently of the invalid ones. *FEF*, 130 S. Ct. at 3161. Here, even apart from the centrality of the mandate and insurance regulations to the functioning of the whole, the unusual legislative proceedings further confirm that, absent those provisions, the Act would not have been enacted in anything even resembling its current form. The Act emerged only after extended, hard-fought, legislative negotiation. Every vote was crucial to its passage, and the vote-trading and log-rolling that developed as a result make this "sweeping and comprehensive Act" (Pet.App. 4a) an unusually unstable grand bargain. Moreover, the shift in the composition of the Senate that preceded the Act's final passage made it *certain* that the bill *could not* have passed without the mandate.

A. The Act Was A Grand Bargain, With Nearly Every Provision Crucial To Its Success

In an oft-cited analysis, Chief Justice Shaw of the Supreme Judicial Court of Massachusetts reasoned that, while "the same act of legislation may be unconstitutional in some of its provisions, and yet constitutional in others," the proposition "must be taken with this limitation": If the parts "are so mutually connected with and dependent on each other, as ***conditions, considerations or compensations*** for each other," then the statute must fall as a whole. *Warren v. Charlestown*, 68 Mass. 84, 98-99 (1854) (emphasis added). This Court long ago adopted that test, directing courts to inquire whether, if "while the bill was pending in Congress a motion to strike out the [invalid] provisions had prevailed," Congress would still have enacted the bill. *Carter*, 298 U.S. at 313, 316; *see also Alaska Airlines*, 480 U.S. at 685 (considering role of invalid provision in "original legislative bargain"). Here, the nature of the debate that produced the bill, and the indications from its drafting history, confirm that the answer is "no."

1. The Act ultimately passed, in both the House and the Senate, by the closest of margins. In the Senate, every affirmative vote was necessary for passage, making every Senator in the majority a swing vote. And the uncertain outcome of the votes shaped negotiations over the bill throughout the legislative process. Dispositive blocs of votes demanded a wide-ranging set of provisions—from the Act's treatment of abortion to its exclusion of the so-called "public" option. Yet other votes were extended in exchange for particular, parochial benefits, such as a Medicaid subsidy for Louisiana; a pilot program for a group of people exposed to asbestos in Montana; and grants to particular, but unnamed, hospitals and universities in other states. *See supra* at 23-25.

This historical context provides strong additional evidence that, if "while the bill was pending in Congress a motion to strike out the [mandate and insurance reforms] had prevailed," *Carter*, 298 U.S.

at 313, the delicate compromises embodied in the Act would have blown up, and there is little chance that Congress would nonetheless have proceeded, unfazed, to enact the remainder of the law.

Separation-of-powers concerns about the judicial displacement of legislative bargains are especially grave in this context. Granted, every statute represents some compromise, but this Act's inherent "conditions, considerations [and] compensations," *Warren*, 68 Mass. at 98-99, are unusually complex and were unusually important to its passage. As the Senate Majority Leader acknowledged, there are more *quid pro quos* in this Act than anyone even knows. *See supra* at 25. For this Court to slice up the legislation in unforeseen, uncontemplated ways—invalidating *quids* and retaining *quos*, likely without even realizing it—would raise profound separation-of-powers concerns regarding the judicial creation of a statute so substantially different, politically as well as operationally, from the one that Congress enacted.

2. Textual confirmation that Congress intended the Act to operate as a package deal can be found in its drafting history—namely, *removal* of an express severability clause. If a law simply *omits* such a clause, its silence "does not raise a presumption against severability." *Alaska Airlines*, 480 U.S. at 686. But here, Congress *removed* a severability clause that *had* been included in an earlier iteration of the bill. H.R. 3962, § 255 (Oct. 29, 2009). While not dispositive, this fact "does suggest that Congress intended to have the various components of the [legislative] package operate together or not at all." *Gubiensio-Ortiz*, 857 F.2d at 1267.

The Eleventh Circuit entirely discounted this drafting history, pointing out that "both the Senate and House legislative drafting manuals state that ... severability clauses are unnecessary." Pet.App. 175a. That may have explained a failure to include a severability clause *at all*, but it hardly explains why Congress went to the effort of *deleting* a clause it had earlier found important enough to include. And, despite the drafting manuals, the very same Congress included—in its other showcase piece of complex legislation, enacted just weeks after the Act—an apparently "unnecessary" severability clause. *See* Dodd-Frank Wall Street Reform and Consumer Protection Act, § 3, Pub. L. No. 111-203 (2010). That fundamental difference between these two landmark statutes is highly probative of congressional intent.

B. Under Congress' Procedural Rules, The Act Could Not Have Been Enacted Without the Individual Mandate

In many cases, determining whether Congress would have enacted the legislation absent its invalid provision may be an "elusive" inquiry. *Chadha*, 462 U.S. at 932. Not so here. The unique procedures by which the Act was passed, following an unexpected change in the political composition of the Senate, provides the plainest evidence imaginable that this bill not only *would not*, but *could not* have been enacted without the mandate.

On December 24, 2009, the Senate passed a health-insurance reform bill with exactly the sixty votes needed to overcome a filibuster the day prior. *Supra* at 8. But when Senator Scott Brown, a staunch opponent of the legislative efforts, was elected soon thereafter, the balance of power shifted, and the Act's proponents could no longer retain its fundamental structure and yet avoid a filibuster. *Supra* at 9. Accordingly, the House of Representatives had no choice but to pass the bill in the *exact* form in which it had already passed the Senate, since a *different* bill emerging from a bicameral conference committee, reconciling the two houses' versions, could not then pass in the Senate. To satisfy the Constitution's requirement that a bill pass both houses in the same form, the House was bound (if it wanted *any* bill remotely resembling the pending one) to pass the Senate's version—which included the mandate and insurance regulations. *Id.*

Thus, the *only* way for Congress to make changes to the bill as passed by the Senate was through the budget reconciliation process, but that process allowed only for *budgetary* provisions. *Id.* Congress therefore was precluded from making any *non-budgetary* amendments to the version of the Act passed by the Senate. In other words, the large parts of the Act that did not affect the budget—*i.e.*, everything aside from the Act's taxes, subsidies, and changes to public programs like Medicare—were unalterable, and thus *essential* to the Act's successful enactment. The point is further confirmed by the rule that the House adopted to govern its consideration of the Senate bill: It allowed for no amendments, requiring instead an all-or-nothing vote on the entire package. *See supra* at 9-10.

This history confirms that the Act, without the mandate or insurance regulations, could not have been enacted. The latter have no direct budgetary impact, and so any attempt to amend them out of the

Act through reconciliation would have failed. The whole statute is thus procedurally—not just operationally—intertwined with the mandate and insurance regulations. It therefore would be doubly inappropriate for this Court to substitute for the Act a law that Congress would not, and could not, have enacted.

CONCLUSION

This Court should hold that the ACA is entirely non-severable from the individual mandate and reverse in relevant part the judgment below.

Respectfully submitted,

KAREN R. HARNED
NFIB SMALL BUSINESS
LEGAL CENTER
1201 F St. NW, Suite 200
Washington, DC 20004

PROF. RANDY E. BARNETT
GEORGETOWN UNIV.
LAW CENTER
600 New Jersey Ave. NW
Washington, DC 20001

MICHAEL A. CARVIN
Counsel of Record
GREGORY G. KATSAS
C. KEVIN MARSHALL
HASHIM M. MOOPPAN
YAAKOV M. ROTH
JONES DAY
51 Louisiana Ave. NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

Counsel for Private Petitioners

Dated: January 6, 2012

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TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended—

(1) by striking the part heading and inserting the following:

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS";

(2) by redesignating sections 2704 through 2707 as sections 2725 through 2728, respectively;

(3) by redesignating sections 2711 through 2713 as sections 2731 through 2733, respectively;

(4) by redesignating sections 2721 through 2723 as sections 2735 through 2737, respectively; and

(5) by inserting after section 2702, the following:

"Subpart II—Improving Coverage

"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

"(a) PROHIBITION.—

"(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—

"(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or

"(B) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.

"(2) ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term 'restricted annual limit' for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

"(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage that is not required to provide essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act from placing annual or lifetime per beneficiary limits on specific covered benefits to the extent that such limits are otherwise permitted under Federal or State law.

"SEC. 2712. PROHIBITION ON RESCISSIONS.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

"SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

"(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

"(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and

"(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

"(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

"(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

"(b) Interval.—

"(1) IN GENERAL.—The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

"(2) MINIMUM.—The interval described in paragraph (1) shall not be less than 1 year.

"(c) Value-BASED INSURANCE DESIGN.—The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

"SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Nothing in this section shall require a health plan or a health insurance issuer described in the preceding sentence to make coverage available for a child of a child receiving dependent coverage.

"(b) REGULATIONS.—The Secretary shall promulgate regulations to define the dependents to which coverage shall be made available under subsection (a).

"(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the definition of 'dependent' as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

"SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

"(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to applicants, enrollees, and policyholder or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the 'NAIC'), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

"(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

"(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

"(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

"(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes—

"(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

"(B) a description of the coverage, including cost sharing for—

"(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

"(ii) other benefits, as identified by the Secretary;

"(C) the exceptions, reductions, and limitations on coverage;

"(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

"(E) the renewability and continuation of coverage provisions;

"(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios to be based on recognized clinical practice guidelines;

"(G) a statement of whether the plan or coverage—

"(i) provides minimum essential coverage (as defined under section 5000A(f) of the Internal Revenue Code 1986); and

"(ii) ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs;

"(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

"(I) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

"(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

"(d) REQUIREMENT TO PROVIDE.—

"(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

"(A) an applicant at the time of application;

"(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

"(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

"(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage described in subsection (a) is provided in paper or electronic form.

"(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

"(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

"(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

"(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act of 1974) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

"(e) PREEMPTION.—The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

"(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

"(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

"(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance- related terms described in paragraph (2) and the medical terms described in paragraph (3).

"(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

"(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

"SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

"(a) IN GENERAL.— A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of the Internal Revenue Code of 1986 (relating to prohibition on discrimination in favor of highly compensated individuals).

"(b) RULES AND DEFINITIONS.—For purposes of this section—

"(1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of such Code shall apply.

"(2) HIGHLY COMPENSATED INDIVIDUAL.—The term 'highly compensated individual' has the meaning given such term by section 105(h)(5) of such Code.

"SEC. 2717. ENSURING THE QUALITY OF CARE.

"(a) QUALITY REPORTING.—

"(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

"(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

"(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

"(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

"(D) implement wellness and health promotion activities.

"(2) REPORTING REQUIREMENTS.—

"(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

"(B) TIMING OF REPORTS.—A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

"(C) AVAILABILITY OF REPORTS.—The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

"(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

"(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

"(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

"(1) Smoking cessation.

"(2) Weight management.
"(3) Stress management.
"(4) Physical fitness.
"(5) Nutrition.
"(6) Heart disease prevention.
"(7) Healthy lifestyle support.
"(8) Diabetes prevention.

"(c) PROTECTION OF SECOND AMENDMENT GUN RIGHTS.—

"(1) WELLNESS AND PREVENTION PROGRAMS.— A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

"(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

"(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

"(2) LIMITATION ON DATA COLLECTION.—None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

"(A) the lawful ownership or possession of a firearm or ammunition;

"(B) the lawful use of a firearm or ammunition; or

"(C) the lawful storage of a firearm or ammunition.

"(3) LIMITATION ON DATABASES OR DATA BANKS.— None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

(4) LIMITATION ON DETERMINATION OF PREMIUM RATES OR ELIGIBILITY FOR HEALTH INSURANCE.—A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

"(A) the lawful ownership or possession of a firearm or ammunition; or

"(B) the lawful use or storage of a firearm or ammunition.

(5) LIMITATION ON DATA COLLECTION REQUIREMENT FOR INDIVIDUALS.—No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

"(A) the lawful ownership or possession of a firearm or ammunition; or

"(B) the lawful use, possession, or storage of a firearm or ammunition.

"(d) REGULATIONS.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

"(e) STUDY AND REPORT.—Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

"SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.

"(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

"(1) on reimbursement for clinical services provided to enrollees under such coverage;

"(2) for activities that improve health care quality; and

"(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

"(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR PREMIUM PAYMENTS.—

"(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—

"(A) REQUIREMENT.—Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if that ratio of the amount that is equal to the amount by which premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

"(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

"(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of 80 percent may destabilize the individual market in such State.

"(B) REBATE AMOUNT.—

"(i) CALCULATION OF AMOUNT.—The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

"(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

"(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

"(ii) CALCULATION BASED ON AVERAGE RATIO.—Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

"(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

"(3) ENFORCEMENT.—The provisions Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

"(c) DEFINITIONS.— Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

"(d) ADJUSTMENTS.—The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

"(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

"SEC. 2719. APPEALS PROCESS.

"(a) INTERNAL CLAIMS APPEALS.—

"(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

"(A) have in effect an internal claims appeal process;

"(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

"(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

"(2) ESTABLISHED PROCESSES.—To comply with paragraph (1)—

"(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

"(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

"(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

"(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

"(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

"(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

"(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

"(c) SECRETARY AUTHORITY.—The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of this section, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.

"SEC. 2719A PATIENT PROTECTIONS.

"(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

"(b) COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.— If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

"(A) without the need for any prior authorization determination;

"(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

"(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

"(i) by a nonparticipating health care provider with or without prior authorization; or

"(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

"(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

"(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

"(2) DEFINITIONS.—In this subsection:

"(A) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

"(B) EMERGENCY SERVICES.—The term 'emergency services' means, with respect to an emergency medical condition—

"(i) a medical screening examination (as required under section 1867 of the Social

Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

"(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

"(C) STABILIZE.—The term 'to stabilize', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

"(c) ACCESS TO PEDIATRIC CARE.—

"(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

"(d) Patient Access to Obstetrical and Gynecological Care.—

"(1) General Rights.—

"(A) Direct Access.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

"(B) Obstetrical and Gynecological Care.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

"(2) Application of Paragraph.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—

"(A) provides coverage for obstetric or gynecologic care; and

"(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

"(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

"(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

"(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.".

SEC. 1003 ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

"SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR THEIR DOLLARS.

"(a) INITIAL PREMIUM REVIEW PROCESS.—

"(1) IN GENERAL.—The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

"(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

"(b) CONTINUING PREMIUM REVIEW PROCESS.—

"(1) INFORMING SECRETARY OF PREMIUM INCREASE PATTERNS.—As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

"(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

"(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

"(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

"(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

"(B) CONSIDERATION IN OPENING EXCHANGE.— In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

"(c) GRANTS IN SUPPORT OF PROCESS.—

"(1) PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.—

The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

"(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage;

"(B) in providing information and recommendations to the Secretary under subsection (b)(1); and

"(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.

"(2) FUNDING.—

"(A) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

"(B) FURTHER AVAILABILITY FOR INSURANCE REFORM AND CONSUMER PROTECTION.—If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

"(C) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

"(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and "(ii) no State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year."

"(d) MEDICAL REIMBURSEMENT DATA CENTERS.—

"(1) FUNCTIONS.—A center established under subsection (c)(1)(C) shall—

"(A) develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;

"(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

"(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

"(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

"(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

"(2) CONFLICTS OF INTEREST.—A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such bylaws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center's analysis of health care costs.

"(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to permit a center established under subsection (c)(1)(C) to compel health insurance issuers to provide data to the center.".

Subtitle C—Quality Health Insurance Coverage for All Americans

PART 1—HEALTH INSURANCE MARKET REFORMS

SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 1001, is further amended—

(1) by striking the heading for subpart 1 and inserting the following:

"Subpart I—General Reform";

(2)(A) in section 2701 (42 U.S.C. 300gg), by striking the section heading and subsection (a) and inserting the following:

"SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage."; and

(B) by transferring such section (as amended by subparagraph (A)) so as to appear after the section 2703 added by paragraph (4);

(3)(A) in section 2702 (42 U.S.C. 300gg–1)—

(i) by striking the section heading and all that follows through subsection (a);

(ii) in subsection (b)—

(I) by striking "health insurance issuer offering health insurance coverage in connection with a group health plan" each place that such appears and inserting "health insurance issuer offering group or individual health insurance coverage"; and

(II) in paragraph (2)(A)—

(aa) by inserting "or individual" after "employer"; and

(bb) by inserting "or individual health coverage, as the case may be" before the semicolon; and

(iii) in subsection (e)—

(I) by striking "(a)(1)(F)" and inserting "(a)(6)";

(II) by striking "2701" and inserting "2704"; and

(III) by striking "2721(a)" and inserting "2735(a)"; and

(B) by transferring such section (as amended by subparagraph (A)) to appear after section 2705(a) as added by paragraph (4); and

(4) by inserting after the subpart heading (as added by paragraph (1)) the following:

"SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

"(a) PROHIBITING DISCRIMINATORY PREMIUM RATES.—

"(1) IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

"(A) such rate shall vary with respect to the particular plan or coverage involved only by—

"(i) whether such plan or coverage covers an individual or family;

"(ii) rating area, as established in accordance with paragraph (2);

"(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

"(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

"(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

"(2) RATING AREA.—

"(A) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

"(B) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

"(3) PERMISSIBLE AGE BANDS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

"(4) APPLICATION OF VARIATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

"(5) SPECIAL RULE FOR LARGE GROUP MARKET.—If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

"SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

"(a) GUARANTEED ISSUANCE OF COVERAGE IN THE INDIVIDUAL AND GROUP MARKET.—Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

"(b) ENROLLMENT.—

"(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

"(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 603 of the Employee Retirement Income Security Act of 1974).

"(3) REGULATIONS.—The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

“SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.

“(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.

“SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

“(a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

“(1) Health status.

“(2) Medical condition (including both physical and mental illnesses).

“(3) Claims experience.

“(4) Receipt of health care.

“(5) Medical history.

“(6) Genetic information.

“(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

“(8) Disability.

“(9) Any other health status-related factor determined appropriate by the Secretary.

“(j) PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—

“(1) GENERAL PROVISIONS.—

"(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a 'wellness program') shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

"(B) NO CONDITIONS BASED ON HEALTH STATUS FACTOR.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraph (2) are complied with.

"(C) CONDITIONS BASED ON HEALTH STATUS FACTOR.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

"(2) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor (or if such a wellness program does not provide such a reward), the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

"(A) A program that reimburses all or part of the cost for memberships in a fitness center.

"(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

"(C) A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits).

"(D) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

"(E) A program that provides a reward to individuals for attending a periodic health education seminar.

"(3) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are complied with:

"(A) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

"(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

"(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

"(D) The full reward under the wellness program shall be made available to all similarly situated individuals. For such purpose, among other things:

"(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

"(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

"(II) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

"(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

"(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subparagraph shall not be required.

"(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

"(l) WELLNESS PROGRAM DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project under which participating States shall apply the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

"(2) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

"(3) REQUIREMENTS.—

"(A) MAINTENANCE OF COVERAGE.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State's project is designed in a manner that—

"(i) will not result in any decrease in coverage; and

"(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

"(B) OTHER REQUIREMENTS.—States that participate in the demonstration project under this subsection—

"(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adherence to, or participation in, a reasonably designed program of health promotion and disease prevention;

"(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

"(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

"(I) do not create undue burdens for individuals insured in the individual market;

"(II) do not lead to cost shifting; and

"(III) are not a subterfuge for discrimination;

"(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and

"(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the project reflect the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

"(m) REPORT.—

"(1) IN GENERAL.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

"(A) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

"(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

"(C) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

"(D) the effectiveness of different types of rewards.

"(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

"(n) REGULATIONS.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.

"SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

"(a) PROVIDERS.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

"(b) INDIVIDUALS.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

"SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

"(a) COVERAGE FOR ESSENTIAL HEALTH BENEFITS PACKAGE.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.

"(b) COST-SHARING UNDER GROUP HEALTH PLANS.—A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c).

"(c) CHILD-ONLY PLANS.—If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d) of the Patient Protection and Affordable Care Act, the issuer shall also offer such coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

"(d) DENTAL ONLY.—This section shall not apply to a plan described in section 1302(d)(2)(B)(ii)(I).

"SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERIODS.

"A group health plan and a health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in section 2704(b)(4)) that exceeds 90 days.'

"SEC. 2709 COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

"(a) COVERAGE.—

"(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

"(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

"(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

"(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

"(2) ROUTINE PATIENT COSTS.—

"(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

"(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

"(i) the investigational item, device, or service,

itself;

"(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or "(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

"(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

"(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

"(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

"(2) Either—

"(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

"(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

"(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

"(d) APPROVED CLINICAL TRIAL DEFINED.—

"(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

"(A) FEDERALLY FUNDED TRIALS.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

"(i) The National Institutes of Health.

"(ii) The Centers for Disease Control and Prevention.

"(iii) The Agency for Health Care Research and

Quality.

"(iv) The Centers for Medicare & Medicaid Services.

"(v) cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

"(vi) A qualified non-governmental research entity

identified in the guidelines issued by the National Institutes of Health for center support grants.

"(vii) Any of the following if the conditions described in paragraph (2) are met:

"(I) The Department of Veterans Affairs.

"(II) The Department of Defense.

"(III) The Department of Energy.

"(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

"(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

"(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

"(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

"(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

"(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term 'life-threatening condition' means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

"(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

"(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.".

Subtitle D—Available Coverage Choices for All Americans

PART 1—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.

(a) QUALIFIED HEALTH PLAN.—In this title:

(1) IN GENERAL.—The term "qualified health plan" means a health plan that—

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 1302(a); and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322, and a multi-State plan under section 1334, unless specifically provided for otherwise.

(3) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

(4) VARIATION BASED ON RATING AREA.—A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term "health plan" means health insurance coverage and a group health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term "health plan" shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms "health insurance coverage" and "health insurance issuer" have the meanings given such terms by section 2791(b) of the Public Health Service Act.

(3) GROUP HEALTH PLAN.—The term "group health plan" has the meaning given such term by section 2791(a) of the Public Health Service Act.

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term "essential health benefits package" means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.—

(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(2) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS.—

(A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—

(i) $2,000 in the case of a plan covering a single individual; and

(ii) $4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

(B) INDEXING OF LIMITS.—In the case of any plan year beginning in a calendar year after 2014—

(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) the dollar amount under subparagraph (A)(ii) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the calendar year, determined after application of clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(C) ACTUARIAL VALUE.—The limitation under this paragraph shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

(D) COORDINATION WITH PREVENTIVE LIMITS.—Nothing in this paragraph shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the Public Health Service Act.

(3) COST-SHARING.—In this title—

(A) IN GENERAL.—The term "cost-sharing" includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) LEVELS OF COVERAGE.—

(1) LEVELS OF COVERAGE DEFINED.—The levels of coverage described in this subsection are as follows:

(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) ACTUARIAL VALUE.—

(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) EMPLOYER CONTRIBUTIONS.—The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) APPLICATION.—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS. .—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Subpart A—Premium Tax Credits and Cost-sharing Reductions

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

"**SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.**

"(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

"(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

"(1) IN GENERAL.—The term 'premium assistance credit amount' means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

"(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

"(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

"(B) the excess (if any) of—

"(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

"(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

"(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

"(A) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

"In the case of household income (expressed as a percent of poverty line) with the following income tier	The initial premium percentage is—	The final premium percentage is—
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

"(ii) INDEXING.—

"(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

"(II) ADDITIONAL ADJUSTMENT.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

"(III) FAILSAFE.—Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and costsharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

"(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

"(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

"(ii) provides—

"(I) self-only coverage in the case of an applicable taxpayer—

"(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

"(bb) who is not described in item (aa) but who purchases only self-only coverage, and

"(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

"(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

"(D) ADDITIONAL BENEFITS.—If—

"(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

"(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

"(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

"(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

"(1) APPLICABLE TAXPAYER.—

"(A) IN GENERAL.—The term 'applicable taxpayer' means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

"(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

"(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

"(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of such alien status, the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

"(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

"(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(2) COVERAGE MONTH.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'coverage month' means, with respect to an applicable taxpayer, any month if—

"(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

"(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

"(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

"(i) IN GENERAL.—The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

"(ii) MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' has the meaning given such term by section 5000A(f).

"(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

"(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

"(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

"(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

"(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

"(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

"(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(D) EXCEPTIONS FOR INDIVIDUALS RECEIVING FREE CHOICE VOUCHERS.—The term 'coverage month' shall not include any month in which such individual has a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act.

"(3) DEFINITIONS AND OTHER RULES.—

"(A) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

"(B) GRANDFATHERED HEALTH PLAN.—The term 'grandfathered health plan' has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

"(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(2) HOUSEHOLD INCOME.—

"(A) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of—

"(i) the modified adjusted gross income of the taxpayer, plus

"(ii) the aggregate modified adjusted gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(B) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income increased by—

"(i) any amount excluded from gross income under section 911, and

"(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) POVERTY LINE.—

"(A) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

"(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

"(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

"(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

"(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

"(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

"(i) A method under which—

"(I) the taxpayer's family size is determined by not taking such individuals into account, and

"(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

"(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

"(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

"(ii) A comparable method reaching the same result as the method under clause (i).

"(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

"(3) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

"(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

"(1) IN GENERAL.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

"(2) EXCESS ADVANCE PAYMENTS.—

"(A) IN GENERAL.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

"(B) LIMITATION ON INCREASE WHERE INCOME LESS THAN 400 PERCENT OF POVERTY LINE.—

"(i) IN GENERAL.—In the case of an applicable taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed $400 ($250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

"(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2013' for 'calendar year 1992' in subparagraph (B) thereof.

(3) INFORMATION REQUIREMENT.—Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

"(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

"(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

"(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

"(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

"(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

"(F) Information necessary to determine whether a taxpayer has received excess advance payments.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

"(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

"(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

"(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.".

(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.".

(c) STUDY ON AFFORDABLE COVERAGE.—

(1) STUDY AND REPORT.—

(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term "appropriate committees of Congress" means the Committee on Ways and

Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting "36B," after "36A,".

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

"Sec. 36B. Refundable credit for coverage under a qualified health plan.".

(3) Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by inserting "36B," after "36A,".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

"Sec. 5000A. Requirement to maintain minimum essential coverage.

"SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

"(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

"(b) SHARED RESPONSIBILITY PAYMENT.—

"(1) IN GENERAL.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayers is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

"(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

"(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

"(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

"(c) AMOUNT OF PENALTY.—

"(1) IN GENERAL.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

"(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

"(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

"(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

"(A) FLAT DOLLAR AMOUNT. .—AN AMOUNT EQUAL TO THE LESSER OF—

"(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

"(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

"(B) PERCENTAGE OF INCOME.— An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

"(i) 1.0 percent for taxable years beginning in 2014.

"(ii) 2.0 percent for taxable years beginning in 2015.

"(iii) 2.5 percent for taxable years beginning after 2015.

"(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $750.

"(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $325 for 2015.

"(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

"(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

"(i) $695, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

"(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

"(i) the modified *adjusted* gross income of the taxpayer, plus

"(ii) the aggregate modified *adjusted* gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1),and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(C) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income increased by—

"(i) any amount excluded from gross income— under section 911, and,

"(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

"(2) RELIGIOUS EXEMPTIONS.—

"(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is

"(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and "(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

"(B) HEALTH CARE SHARING MINISTRY.—

"(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

"(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

"(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

"(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

"(III) members of which retain membership even after they develop a medical condition,

"(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

"(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

"(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

"(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

"(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

"(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

"(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

"(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

"(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

"(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

"(2) TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6102(a)(1) with respect to the taxpayer.

"(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

"(4) MONTHS DURING SHORT COVERAGE GAPS.—

"(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

"(B) SPECIAL RULES.—For purposes of applying this paragraph—

"(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

"(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

"(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

"(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of

Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship.

"(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

"(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:

"(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

"(i) the Medicare program under part A of title XVIII of the Social Security Act,

"(ii) the Medicaid program under title XIX of the Social Security Act,

"(iii) the CHIP program under title XXI of the Social Security Act,

"(iv) the TRICARE for Life program,

"(v) the veteran's health care program under chapter 17 of title 38, United States Code, or

"(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

"(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

"(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

"(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

"(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

"(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

"(A) a GOVERNMENTAL plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

"(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

"(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—

"(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

"(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

"(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

"(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

"(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

"(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the

Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

"(g) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) SPECIAL RULES.—Notwithstanding any other provision of law—

"(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

"(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

"(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

"(ii) levy on any such property with respect to such failure.".

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

"(a) LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.—If—

"(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

"(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

"(b) LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.—

"(1) IN GENERAL.—If—

"(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

"(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and an amount equal to 1/12 of $3,000.

"(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

"(3) SPECIAL RULES FOR EMPLOYERS PROVIDING FREE CHOICE VOUCHERS. .— No assessable payment shall be imposed under paragraph (1) for any month with respect to any employee to whom the employer provides a free choice voucher under section 10108 of the Patient Protection and Affordable Care Act for such month.

"(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) APPLICABLE PAYMENT AMOUNT.—The term 'applicable payment amount' means, with respect to any month, 1/12 of $2000.

"(2) APPLICABLE LARGE EMPLOYER.—

"(A) IN GENERAL.—The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

"(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

"(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—

"(I) the employer's workforce exceeds 50 fulltime employees for 120 days or fewer during the calendar year, and

"(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

"(ii) DEFINITION OF SEASONAL WORKERS.—The term 'seasonal worker' means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

"(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

"(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

"(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(iii) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

"(D) APPLICATION OF EMPLOYER SIZE TO ASSESSABLE PENALTIES.—

"(i) IN GENERAL. .—The number of individuals employed by an APPLICABLE large employer as full-time employees during any month shall be reduced by 30 solely for purposes of calculating—

"(I) the assessable payment under subsection (a), or

"(II) the overall limitation under subsection (b)(2).

"(ii) AGGREGATION.—In the case of persons treated as 1 employer under subparagraph (C)(i), only 1 reduction under subclause (I) or (II) shall be allowed with respect to such persons and such reduction shall be allocated among such persons ratably on the basis of the number of full-time employees employed by each such person.

"(E) FULL-TIME EQUIVALENTS TREATED AS FULL-TIME EMPLOYEES.— Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

"(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—The term 'applicable premium tax credit and cost-sharing reduction' means—

"(A) any premium tax credit allowed under section 36B,

"(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

"(C) any advance payment of such credit or reduction under section 1412 of such Act.

"(4) FULL-TIME EMPLOYEE.—

"(A) IN GENERAL.—The term 'full-time employee' means, with respect to any month, an employee who is employed on average at least 30 hours of service per week.

"(B) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

"(5) INFLATION ADJUSTMENT.—

"(A) IN GENERAL.—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b) and paragraph (1) shall be increased by an amount equal to the product of—

"(i) such dollar amount, and

"(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient

Protection and Affordable Care Act) for the calendar year.

"(B) ROUNDING.—If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

"(6) OTHER DEFINITIONS.—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

"(7) TAX NONDEDUCTIBLE.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

"(e) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) TIME FOR PAYMENT.—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

"(3) COORDINATION WITH CREDITS, ETC..—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

"Sec. 4980H. Shared responsibility for employers regarding health coverage.".

(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS' WAGES.—

(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 9001- EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

"SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

"(a) IMPOSITION OF TAX.—If—

"(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

"(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.

"(b) EXCESS BENEFIT.—For purposes of this section—

"(1) IN GENERAL.—The term 'excess benefit' means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

"(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

"(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

"(B) an amount equal to 1⁄12 of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

"(3) ANNUAL LIMITATION.—For purposes of this subsection—

"(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

"(B) APPLICABLE ANNUAL LIMITATION.—

"(i) IN GENERAL.—Except as provided in clause (ii) the annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

"(ii) MULTIMEMPLOYER PLAN COVERAGE.—Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage.

"(C) APPLICABLE DOLLAR LIMIT—Except as provided in subparagraph (D)—

"(i) 2018.—In the case of 2018, the dollar limit under this subparagraph is—

"(I) in the case of an employee with self-only coverage, $10,200 multiplied by the health cost adjustment percentage (determined by only taking into account self-only coverage), and

"(II) in the case of an employee with coverage other than self-only coverage, $27,500 multiplied by the health cost adjustment percentage (determined by only taking into account coverage other than self-only coverage).

"(ii) HEALTH COST ADJUSTMENT PERCENTAGE.—For purposes of clause (i), the health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—

"(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over

"(II) 55 percent.

"(iii) AGE AND GENDER ADJUSTMENT. —

"(I) IN GENERAL.— The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under subclause (II).

"(II) AMOUNT DETERMINED.—The amount determined under this subclause is an amount equal to the excess (if any) of—

"(aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over

"(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.

"(iv) EXCEPTION FOR CERTAIN INDIVIDUALS.— In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

"(I) the dollar amount in clause (i)(I) shall be increased by $1,650, and

"(II) the dollar amount in clause (i)(II) shall be increased by $3,450.

"(iii) SUBSEQUENT YEARS.—In the case of any calendar year after 2018, each of the dollar amounts under clauses (i) (after the application of clause (ii)) and (iv) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

"(I) such amount as so in effect, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for '1992' in subparagraph (B) thereof), increased by 1 percentage point in the case of determinations for calendar years beginning before 2020.

If any amount determined under this clause is not a multiple of $50, such amount shall be rounded to the nearest multiple of $50.

"(c) LIABILITY TO PAY TAX.—

"(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

"(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

"(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

"(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

"(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

"(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider's applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

"(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

"(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

"(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

"(A) IN GENERAL.—Each employer shall—

"(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

"(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

"(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

"(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

"(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

"(A) IN GENERAL.—The term 'applicable employer-sponsored coverage' means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

"(B) EXCEPTIONS.—The term 'applicable employer-sponsored coverage' shall not include—

"(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care, or

"(ii) any policy under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, or

"(iii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

"(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

"(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

"(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

"(2) DETERMINATION OF COST.—

"(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

"(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

"(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

"(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

"(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

"(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

"3) EMPLOYEE.—The term 'employee' includes any former employee, surviving spouse, or other primary insured individual.

"(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

"(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

"(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

"(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

"(2) LIMITATIONS ON PENALTY.—

"(A) PENALTY NOT TO APPLY WHERE FAULURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

"(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

"(i) such failure was due to reasonable cause and not to willful neglect, and

"(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

"(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

"(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) COVERAGE DETERMINATIONS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

"(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

"(2) QUALIFIED RETIREE.—The term 'qualified retiree' means any individual who—

"(A) is receiving coverage by reason of being a retiree,

"(B) has attained age 55, and

"(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

"(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term 'employees engaged in a high-risk profession' means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.

"(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).

"(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

"(A) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

"(B) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term by section 9832(b)(2).

"(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term 'person that administers the plan benefits' shall include the plan sponsor if the plan sponsor administers benefits under the plan.

"(7) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"(8) TAXABLE PERIOD.—The term 'taxable period' means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

"(9) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

"(10) DENIAL OF DEDUCTION.—For denial of a deduction for the tax imposed by this section, see section 275(a)(6).

"(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by section 1513, is amended by adding at the end the following new item:

"Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W-2.

(a) IN GENERAL.—Section 6051(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking "and" at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ", and", and by adding after paragraph (13) the following new paragraph:

> "(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—
>
> > "(A) coverage to which paragraphs (11) and (12) apply, or
> >
> > "(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAS.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: "Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.".

(b) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: "Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.".

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.".

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2010.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010.

SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) HSAS.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking "10 percent" and inserting "20 percent".

(b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking "15 percent" and inserting "20 percent".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2010.

SEC. 9005. LIMITATIONS ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

"(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

"(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

"(2) ADJUSTMENT FOR INFLATION.— In the case of any taxable year beginning after December 31, 2013, the dollar amount in paragraph (1) shall be increased by an amount equal to—

"(A) such amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2012' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

"(h) APPLICATION TO CORPORATIONS.—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term 'person' includes any corporation that is not an organization exempt from tax under section 501(a).

"(i) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.".

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting "amounts in consideration for property," after "wages,",

(2) by inserting "gross proceeds," after "emoluments, or other", and

(3) by inserting "gross proceeds," after "setting forth the amount of such".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) REQUIREMENTS TO QUALIFY AS SECTION 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:

"(r) ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.—

"(1) IN GENERAL.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

"(A) meets the community health needs assessment requirements described in paragraph (3),

"(B) meets the financial assistance policy requirements described in paragraph (4),

"(C) meets the requirements on charges described in paragraph (5), and

"(D) meets the billing and collection requirement described in paragraph (6).

"(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—

"(A) IN GENERAL.—This subsection shall apply to—

"(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

"(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

"(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—If a hospital organization operates more than 1 hospital facility—

"(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

"(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

"(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

"(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

"(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year, and

"(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

"(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

"(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

"(ii) is made widely available to the public.

"(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

"(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

"(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

"(ii) the basis for calculating amounts charged to patients,

"(iii) the method for applying for financial assistance,

"(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of nonpayment, including collections action and reporting to credit agencies, and

"(v) measures to widely publicize the policy within the community to be served by the organization.

"(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

"(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

"(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the amounts generally billed to individuals who have insurance covering such care, and

"(B) prohibits the use of gross charges.

"(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

"(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).".

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

"SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

"If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.".

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

"Sec. 4959. Taxes on failures by hospital organizations.".

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary's delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking "and" at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

"(15) in the case of an organization to which the requirements of section 501(r) apply for the taxable year—

"(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and

"(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statement).".

(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking "and" at the end of subparagraph (B), by inserting "and" at the end of subparagraph (C), and by adding at the end the following new subparagraph:

"(D) section 4959 (relating to taxes on failures by hospital organizations),".

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding—

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) unreimbursed costs for services provided with respect to non-means tested government programs.

(B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

(A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

(B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning after the date which is 2 years after the date of the enactment of this Act.

(3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.

SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity's branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate branded prescription	The percentage of such sales taken into account is:

drug sales during the calendar year that are:	
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $125,000,000.	10 percent
More than $125,000,000 but not more than $225,000,000.	40 percent
More than $225,000,000 but not more than $400,000,000.	75 percent
More than $400,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity's branded prescription drug sales on the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(4) APPLICABLE AMOUNT.—For purposes of paragraph (1), the applicable amount shall be determined in accordance with the following table:

Calendar year	Applicable amount
2011	$2,500,000,000
2012	$2,800,000,000
2013	$2,800,000,000
2014	$3,000,000,000
2015	$3,000,000,000

2016	$3,000,000,000
2017	$4,000,000,000
2018	$4,100,000,000
2019 and thereafter	$2,800,000,000

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under subsection (a).

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term "covered entity" means any manufacturer or importer with gross receipts from branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(3) JOINT AND SEVERAL LIABILITY.—If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (2), all such persons shall be jointly and severally liable for payment of such fee.

(e) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—

(1) IN GENERAL.—The term "branded prescription drug sales" means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.

(2) BRANDED PRESCRIPTION DRUGS.—

(A) IN GENERAL.—The term "branded prescription drug" means—

(i) any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or

(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(B) PRESCRIPTION DRUG.—For purposes of subparagraph (A)(i), the term "prescription drug" means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) EXCLUSION OF ORPHAN DRUG SALES.—The term "branded prescription drug sales" shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare

disease or condition with respect to which such credit was allowed.

(4) SPECIFIED GOVERNMENT PROGRAM.—The term "specified government program" means—

(A) the Medicare Part D program under part D of title XVIII of the Social Security Act,

(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,

(C) the Medicaid program under title XIX of the Social Security Act,

(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,

(E) any program under which branded prescription drugs are procured by the Department of Defense, or

(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(f) TAX TREATMENTS OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code, shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction using the following methodology:

(1) MEDICARE PART D PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—

(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price concession provided by the covered entity, as reported to the Secretary of Health and Human Services by the prescription drug plans and Medicare Advantage prescription drug plans, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.

(2) MEDICARE PART B PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part B program under section 1862(a) of the Social Security Act, the product of—

(A) the per-unit average sales price (as defined in section 1847A(c) of the Social Security Act) or the per-unit Part B payment rate for a separately paid branded prescription drug without a reported average sales price, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the units and the allocated price for purposes of this section for those branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.

(3) MEDICAID PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—

(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(B) the number of units of the branded prescription drug paid for under the Medicaid program.

(4) DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.

(5) DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.—The Secretary of Defense shall report, for each covered entity and for each branded

prescription drug of the covered entity, the sum of—

(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and

(B) for each such branded prescription drug dispensed under the TRICARE retail pharmacy program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program.

(h) SECRETARY.—For purposes of this section, the term "Secretary" includes the Secretary's delegate.

(i) GUIDANCE.—The Secretary of the Treasury shall publish guidance necessary to carry out the purposes of this section.

(j) EFFECTIVE DATE.—This section shall apply to calendar years beginning after December 31, 2010.

(k) CONFORMING AMENDMENT.—Section 1841(a) of the Social Security Act is amended by inserting "or section 9008(c) of the Patient Protection and Affordable Care Act of 2009" after "this part".

SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

Subchapter E—Medical Devices

"Sec. 4191. Medical devices.

"SEC. 4191. MEDICAL DEVICES.

"(a) IN GENERAL.—There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a tax equal to 2.3 percent of the price for which so sold.

"(b) TAXABLE MEDICAL DEVICE.—For purposes of this section—

"(1) IN GENERAL.—The term 'taxable medical device' means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.

"(2) EXEMPTIONS.—Such term shall not include— '

'(A) eyeglasses,

"(B) contact lenses,

"(C) hearing aids, and

"(D) any other medical device determined by the Secretary to be of a type which is generally purchased by the general public at retail for individual use.", and

(2) by INSERTING after the item relating to subchapter D in the table of subchapters for such chapter the following new item:

"SUBCHAPTER E. MEDICAL DEVICES".

(b) Certain Exemptions Not to Apply.—

(1) Section 4221(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: "In the case of the tax imposed by section 4191, paragraphs (3), (4), (5), and (6) shall not apply.".

(2) Section 6416(b)(2) of such Code is amended by adding at the end the following: "In the case of the

tax imposed by section 4191, subparagraphs (B), (C), (D), and (E) shall not apply.".

(c) Effective Date.—The amendments made by this section shall apply to sales after December 31, 2012.

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2013 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1),

(A) IN GENERAL. .—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written during the calendar year are:	The percentage of net premiums written that are taken into account is:
Not more than $25,000,000	0 percent
More than $25,000,000 but not more than $50,000,000.	50 percent
More than $50,000,000	100 percent.

(B) PARTIAL EXCLUSION FOR CERTAIN EXEMPT ACTIVITIES.—After the application of subparagraph (A), only 50 percent of the remaining net premiums written with respect to health insurance for any United States health risk that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513 of the Internal Revenue Code of 1986) of any covered entity qualifying under paragraph (3), (4), (26), or (29) of section 501(c) of such Code and exempt from tax under section 501(a) of such Code shall be taken into account.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term "covered entity" means any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks,

(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(C) any entity—

(i) which is incorporated as a nonprofit corporation under a State law,

(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except to the extentas otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and (iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act, and

(D) any entity which is described in section 501(c)(9) of such Code and which is established by an entity provides(other than by an employer or employers) for purposes of providing health insurance coverage through the community health insurance option under section 1323).care benefits.

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

If any entity described in subparagraph (C) or (D) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section.

(4) JOINT AND SEVERAL LIABILITY.— If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (3), all such persons shall be jointly and severally liable for payment of such fee.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term "United States health risk" means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.

(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1)—

(1) YEARS BEFORE 2019.—In the case of calendar years beginning before 2019, the applicable amount shall be determined in accordance with the following table:

Calendar year	Applicable amount
2014	$8,000,000,000
2015	$11,300,000,000
2016	$11,300,000,000
2017	$13,900,000,000
2018	$14,300,000,000

(2) Years after 2018.—In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk for such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) $10,000, plus

(ii) the lesser of—

(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(3) ACCURACY-RELATED PENALTY.—

(A) IN GENERAL.— In the case of any understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year, there shall be paid by the covered entity making such understatement, an amount equal to the excess of—

(i) the amount of the covered entity's fee under this section for the calendar year the Secretary determines should have been paid in the absence of any such understatement, over

(ii) the amount of such fee the Secretary determined based on such understatement.

(B) UNDERSTATEMENT.—For purposes of this paragraph, an understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year is the difference between the amount of such net premiums written as reported on the return filed by the covered entity under paragraph (1) and the amount of such net premiums written that should have been reported on such return.

(C) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A) shall be subject to the provisions of subtitle F of the Internal Revenue Code of 1986 that apply to assessable penalties imposed under chapter 68 of such Code.

(4) TREATMENT OF INFORMATION.— Section 6103 of the Internal Revenue Code of 1986 shall not apply to any information reported under this subsection.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.

(2) UNITED STATES.—The term "United States" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—The term "health insurance" shall not include—

(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

(B) any insurance for long-term care, or

(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2).

(j) EFFECTIVE DATE.—This section shall apply to calendar year beginning after December 31, 2013.

SEC. 9012. ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9013. MODIFICATION OF ITEMIZED DEDUCTION FOR MEDICAL EXPENSES.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking "7.5 percent" and inserting "10 percent".

(b) TEMPORARY WAIVER OF INCREASE FOR CERTAIN SENIORS.—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(f) SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting '7.5 percent' for '10 percent' if such taxpayer or such taxpayer's spouse has attained age 65 before the close of such taxable year.".

(c) CONFORMING AMENDMENT.—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "by substituting '10 percent' for '7.5 percent' " and inserting "without regard to subsection (f) of such section".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) IN GENERAL.—Section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(6) SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.—

"(A) IN GENERAL.—No deduction shall be allowed under this chapter—

"(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds $500,000, or

"(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, which is attributable to services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds $500,000 reduced (but not below zero) by the sum of—

"(I) the applicable individual remuneration for such disqualified taxable year, plus

"(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year (or which would have been taken into account under this clause in a preceding taxable year if this clause were applied by substituting 'December 31, 2009' for 'December 31, 2012' in the matter preceding subclause (I)).

"(B) DISQUALIFIED TAXABLE YEAR.—For purposes of this paragraph, the term 'disqualified taxable year' means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.

"(C) COVERED HEALTH INSURANCE PROVIDER.—For purposes of this paragraph—

"(i) IN GENERAL.—The term 'covered health insurance provider' means—

"(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and

"(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in section 9832(b)(1)) is from minimum essential coverage (as defined in section 5000A(f)).

"(ii) AGGREGATION RULES.—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.

"(D) APPLICABLE INDIVIDUAL REMUNERATION.—For purposes of this paragraph, the term 'applicable individual remuneration' means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4) without regard to subparagraphs (B), (C), and (D) thereof) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration with respect to services performed during the disqualified taxable year.

"(E) DEFERRED DEDUCTION REMUNERATION.—For purposes of this paragraph, the term 'deferred deduction remuneration' means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

"(F) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term 'applicable individual' means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—

"(i) who is an officer, director, or employee in such taxable year, or "(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.

"(G) COORDINATION.—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

"(H) REGULATORY AUTHORITY.—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009, with respect to services performed after such date.

SEC. 9015. ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—

(1) IN GENERAL.—Section 3101(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking "In addition" and inserting the following:

"(1) IN GENERAL.—In addition",

(B) by striking "the following percentages of the" and inserting "1.45 percent of the",

(C) by striking "(as defined in section 3121(b))—" and all that follows and inserting "(as defined in section 3121(b)).", and

(D) by adding at the end the following new paragraph:

"(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) a tax equal to 0.9 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of—

"(A) in the case of a joint return, $250,000,

"(B) in the case of a married taxpayer (as defined in section 7703) filing a separate return, 1⁄2 of the dollar amount determined under subparagraph (A), and

"(C) in any other case, $200,000.".

(2) COLLECTION OF TAX.—Section 3102 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(f) SPECIAL RULES FOR ADDITIONAL TAX.—

"(1) IN GENERAL.—In the case of any tax imposed by section 3101(b)(2), subsection (a) shall only apply to the extent to which the taxpayer receives wages from the employer in excess of $200,000, and the employer may disregard the amount of wages received by such taxpayer's spouse.

"(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

"(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.".

(b) SECA.—

(1) IN GENERAL.—Section 1401(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking "In addition" and inserting the following:

"(1) IN GENERAL.—In addition", and

(B) by adding at the end the following new paragraph:

"(2) ADDITIONAL TAX.—

"(A) IN GENERAL.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) for each taxable year beginning after December 31, 2012, a tax equal to 0.9 percent of the self-employment income for such taxable year which is in excess of—

"(i) in the case of a joint return, $250,000,

"(ii) in the case of a married taxpayer (as defined in section 7703) filing a separate return, 1⁄2 of the dollar amount determined under clause (i), and

"(iii) in any other case, $200,000.

"(B) COORDINATION WITH FICA.—The amounts under clauses (i), (ii), or (iii) (whichever is applicable) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.".

(2) NO DEDUCTION FOR ADDITIONAL TAX.—

(A) IN GENERAL.—Section 164(f) of such Code is amended by inserting "(other than the taxes imposed by section 1401(b)(2))" after "section 1401)".

(B) DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting "(determined without regard to the rate imposed under paragraph (2) of section 1401(b))" after "for such year".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF CERTAIN HEALTH ORGANIZATIONS.

(a) IN GENERAL.—Subsection (c) of section 833 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(5) NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.—Notwithstanding the preceding paragraphs, this section shall not apply to any organization unless such organization's percentage of total premium revenue expended on reimbursement for clinical services provided to enrollees under its policies during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

PETITIONER'S BRIEF

No. 11-400

In the Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTAD, GOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF STATE PETITIONERS ON MEDICAID

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
BLAINE H. WINSHIP
Office of the Attorney General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

January 10, 2012 *(Additional Counsel Listed on Inside Cover)*

THOMAS W. CORBETT, JR.
Governor
LINDA L. KELLY
Attorney General
Commonwealth of
Pennsylvania
16th Floor
Strawberry Square
Harrisburg, PA 17120

MARTY J. JACKLEY
Attorney General
of South Dakota
1302 East Highway 14
Pierre, SD 57501

GREGORY F. ZOELLER
Attorney General of Indiana
302 West Washington Street
Indianapolis, IN 46204

SAMUEL S. OLENS
Attorney General of Georgia
40 Capitol Square, SW
Atlanta, GA 30334

MICHAEL DEWINE
Attorney General of Ohio
DAVID B. RIVKIN
LEE A. CASEY
Baker & Hostetler LLP
Special Counsel
30 East Broad Street
17th Floor
Columbus, OH 43215

JOSEPH SCIARROTTA, JR.
General Counsel
Office of Arizona Governor
JANICE K. BREWER
TOM HORNE
Attorney General of Arizona
1700 West Washington
Street, 9th Floor
Phoenix, AZ 85007

WAYNE STENEJHEM
Attorney General
of North Dakota
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

BRIAN SANDOVAL
Governor of Nevada
State Capitol Building
101 North Carson Street
Carson City, NV 89701

RICHARD SVOBODNY
Acting Attorney General
of Alaska
P.O. Box 110300
Juneau, AK 99811

DEREK SCHMIDT
Attorney General of Kansas
Memorial Hall
120 SW 10th Street
Topeka, KS 66612

GREG ABBOTT
Attorney General of Texas
BILL COBB
Deputy Attorney General
for Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

ALAN WILSON
Attorney General
of South Carolina
P.O. Box 11549
Columbia, SC 29211

LUTHER STRANGE
Attorney General
of Alabama
501 Washington Avenue
Montgomery, AL 36130

BILL SCHUETTE
Attorney General
of Michigan
P.O. Box 30212
Lansing, MI 48909

ROBERT M. MCKENNA
Attorney General
of Washington
1125 Washington Street S.E.
P.O. Box 40100
Olympia, WA 98504

JON BRUNING
Attorney General
of Nebraska
KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508
(402) 471-2834

MARK L. SHURTLEFF
Attorney General of Utah
Capitol Suite #230
P.O. Box 142320
Salt Lake City, UT 84114

JAMES D. "BUDDY" CALDWELL
Attorney General
of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804

JOHN W. SUTHERS
Attorney General
of Colorado
1525 Sherman Street,
Denver, CO 80203

LAWRENCE G. WASDEN
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720

MATTHEW MEAD
Governor of Wyoming
State Capitol
200 West 24th Street
Cheyenne, WY 82002

WILLIAM J. SCHNEIDER
Attorney General of Maine
Six State House Station
Augusta, ME 04333

J.B. VAN HOLLEN
Attorney General of Wisconsin
114 East State Capitol
Madison, WI 53702

TERRY BRANSTAD
Governor of Iowa
107 East Grand Avenue
Des Moines, IA 50319

QUESTION PRESENTED

Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress' spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?

PARTIES TO THE PROCEEDINGS

Petitioners, who were the appellees/cross-appellants below, are 26 States: Florida, by and through Attorney General Pam Bondi; South Carolina, by and through Attorney General Alan Wilson; Nebraska, by and through Attorney General Jon Bruning; Texas, by and through Attorney General Greg Abbott; Utah, by and through Attorney General Mark L. Shurtleff; Louisiana, by and through Attorney General James D. "Buddy" Caldwell; Alabama, by and through Attorney General Luther Strange; Attorney General Bill Schuette, on behalf of the People of Michigan; Colorado, by and through Attorney General John W. Suthers; Pennsylvania, by and through Governor Thomas W. Corbett, Jr., and Attorney General Linda L. Kelly; Washington, by and through Attorney General Robert M. McKenna; Idaho, by and through Attorney General Lawrence G. Wasden; South Dakota, by and through Attorney General Marty J. Jackley; Indiana, by and through Attorney General Gregory F. Zoeller; North Dakota, by and through Attorney General Wayne Stenehjem; Mississippi, by and through Governor Haley Barbour; Arizona, by and through Governor Janice K. Brewer and Attorney General Thomas C. Horne; Nevada, by and through Governor Brian Sandoval; Georgia, by and through Attorney General Samuel S. Olens; Alaska, by and through Acting Attorney General Richard Svobodny; Ohio, by and through Attorney General Michael DeWine; Kansas, by and through Attorney General Derek Schmidt; Wyoming, by and through Governor Matthew H. Mead; Wisconsin, by and through Attorney General J.B. Van Hollen; Maine, by and through Attorney General William J. Schneider; and Governor Terry E. Branstad, on behalf of the People of Iowa.

Respondents, who were the appellants/cross-appellees below, are the U.S. Department of Health & Human Services; Kathleen Sebelius, Secretary, U.S. Department of Health & Human Services; the U.S. Department of Treasury; Timothy F. Geithner, Secretary, U.S. Department of Treasury; the U.S. Department of Labor; and Hilda L. Solis, Secretary, U.S. Department of Labor.

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Nat'l Ass'n of State Budget Officers, *2008 State Expenditure Report* (Fall 2009) 15, 39

S. Rep. No. 93-553 (1973) 4

U.S. Census Bureau, *Federal Aid to States for Fiscal Year 2009* (August 2010) 56

U.S. Gov't Accountability Office, *State and Local Governments: Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs* (GAO-10-899) (July 2010) 18

OPINIONS BELOW

The Eleventh Circuit's opinion (Pet. App. 1a) is reported at 648 F.3d 1235.[1] The District Court's summary judgment opinion (Pet. App. 274a) is reported at 780 F. Supp. 2d 1256. The District Court's motion-to-dismiss opinion (Pet. App. 394a) is reported at 716 F. Supp. 2d 1120.

JURISDICTION

The Eleventh Circuit rendered its decision on August 12, 2011. The States filed a timely petition for certiorari, and this Court granted review of the first question presented on November 14, 2011. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The General Welfare Clause and the Tenth Amendment to the U.S. Constitution, and the relevant provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (collectively, the "ACA" or "Act"), are reproduced in an appendix to this brief.[2]

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[1] For ease of reference, all citations of the Petition Appendix in all briefs arising out of the decision below are of the appendix to the federal government's petition for certiorari in *U.S. Department of Health and Human Services v. Florida*, No. 11-398. Citations of the Eleventh Circuit Record Excerpts are designated "R.E."

[2] All citations of provisions of the "ACA" are of the Affordable Care Act as amended by the Reconciliation Act.

STATEMENT OF THE CASE

A. Statutory Background

1. The Medicaid Program

Congress established Medicaid in 1965. *See* Social Security Act of 1965, Title XIX, codified at 42 U.S.C. § 1396 *et seq.* At its inception, Medicaid was structured as a cooperative federal-state partnership: States that funded certain types of medical assistance for specific categories of needy residents were provided federal reimbursement for at least 50% and as much as 83% of the cost of that assistance.

An individual's eligibility to participate in Medicaid originally piggy-backed on eligibility for one of four public aid programs: Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled. *See* 42 U.S.C. § 1396a(a)(10) (1970). Like Medicaid itself, each of those programs was a state-run cooperative endeavor with the federal government, meaning each left States with significant control over eligibility for participation. Thus, while the Medicaid program as originally conceived required participating States to provide medical assistance to certain categories of individuals—needy families with dependent children, the elderly, the blind, and the disabled—within those categories, States retained real discretion in setting threshold eligibility criteria in accordance with their own budgetary constraints. Moreover, Congress gave States a true choice about whether and how to participate: States' participation in the four other partnerships did not necessitate participation in Medicaid; nor was their discretion in determining eligibility for those programs limited by their acceptance of Medicaid funding.

In its first year, Medicaid covered approximately 4 million individuals and cost about $1 billion nationwide. John D. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Financing Review 105 (Fall 2000) ("Klemm Report").[3] The program's voluntary nature was underscored by the fact that not all States initially decided to participate. The program gradually expanded as more States opted in, and by 1971 it covered approximately 16 million individuals and cost about $6.5 billion. Klemm Report 106.

The first significant alteration to the basic criteria for participation in Medicaid came in 1972, when Congress established Supplemental Security Income for the Aged, Blind, and Disabled ("SSI"). *See* Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, § 301 ("1972 SSA Act"). In doing so, Congress created a single federally administered program that replaced the earlier state-run public aid programs that had, in turn, established Medicaid eligibility for those three categorically needy groups. While Congress left intact Aid to Families with Dependent Children, as well as the States' discretion to determine eligibility for that program, it eliminated the States' role in setting eligibility thresholds for the aged, blind, and disabled individuals previously served by the other three programs. As a result, "[i]n some States the number of individuals eligible for SSI assistance was significantly larger than the number eligible under the earlier, state-run categorical need programs." *Schweiker v. Gray Panthers*, 453 U.S. 34, 38 (1981).

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[3] Available at http://www.nd.edu/~dbetson/courses/documents /BriefHistoryofSpending.pdf.

Congress considered conditioning each State's continued participation in Medicaid on the State's willingness to extend coverage to all individuals made eligible for SSI aid, but it "feared that these States would withdraw from the cooperative Medicaid program rather than expand their Medicaid coverage in a manner commensurate with the expansion of categorical assistance." *Id.* Accordingly, Congress chose not to strong arm States but to accommodate them, offering participating States the option of either expanding coverage to all SSI-eligible individuals (with a corresponding increase in federal funding), or maintaining Medicaid coverage for only those individuals eligible under the State's most recent Medicaid plan. *See id.* at 38–39 & nn.3–6; 1972 SSA Act § 209(b); S. Rep. No. 93-553, at 56 (1973) (noting that Congress created § 209(b) option "in order not to impose a substantial fiscal burden on these States").

As States continued to expand eligibility and coverage, by 1980, Medicaid had grown to a $26 billion program covering more than 20 million individuals, Klemm Report 106–08, leading this Court to recognize that "a complete withdrawal of the federal prop in the system ... could seriously cripple a state's attempts to provide other necessary medical services" to its residents. *Harris v. McRae*, 448 U.S. 297, 309 n.12 (1980) (internal quotation marks omitted).

By 1982, every State was participating, to some extent, in Medicaid. Around the same time, Congress began gradually adding separate eligibility requirements for two new groups: children and pregnant women. Although whether to expand coverage to those two groups was initially left to each State's discretion, Congress eventually demanded coverage for those groups as a criterion for continued participation in Medicaid.[4] By the end of the decade, Congress mandated coverage for all pregnant women, children age 5 and under with family incomes below 133% of the federal poverty level, and children between the ages of 6 and 18 with family incomes below the federal poverty level.[5]

Throughout Medicaid's history, Congress has consistently "give[n] the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'" *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (quoting 42 U.S.C. § 1396a(a)(19)). And while Congress periodically increased eligibility thresholds for certain categories of needy, at no time did Congress establish mandatory coverage criteria for childless adults who are not within the covered categories. Although many States have extended coverage to such individuals voluntarily, whether and to what extent to do so had always remained the prerogative of the States. Congress at times sought to encourage States to retain various existing voluntary expansions of coverage through so-called "maintenance-of-effort" provisions, but those provisions, like the provisions allowing States voluntarily to expand coverage in the first place, have traditionally been incentive-based: Rather than compel States to maintain voluntary expansions, Congress typically offered additional funding to States that agreed to do so.[6]

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[4] *See, e.g.*, Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494, § 2361 (extending coverage to children under age 5 and first-time pregnant women financially eligible for public aid); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, § 9501 (extending coverage to all pregnant women financially eligible for public aid).

[5] *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, 103 Stat. 2106, § 6401; Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, 104 Stat. 1388, § 4601.

2. The ACA's Expansion of Medicaid

The ACA is a 2,700-page collection of sweeping provisions intended to impose "near-universal" health insurance coverage on the Nation. ACA § 1501(a)(1)(D). The Act attempts to achieve that goal by increasing both the demand for and the supply of insurance. On the demand side, the Act's individual mandate requires nearly every individual to obtain a minimum level of health insurance

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[6] *See, e.g.*, Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874, § 9401(b) (offering additional funding to States that agreed to expand eligibility, but only if they also maintained existing payment levels); American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, § 5001(f) (offering additional funding to States that agreed to maintain eligibility standards in effect on July 1, 2008).

coverage. On the supply side, the Act has a set of core components designed to expand the availability of private and public insurance to satisfy the demand forcibly created by the individual mandate. Each of those components targets a distinct segment of the previously uninsured population. The principal means by which Congress sought to ensure coverage for low-income individuals is through a dramatic transformation of Medicaid, scheduled to take effect in 2014 along with the individual mandate.

Title II of the ACA expands the Medicaid program in multiple respects and transforms it from a cooperative program addressed to specific categories of the most needy into a mandatory program designed to fulfill the individual mandate for the entire non-elderly population with income below 138% of the federal poverty line. Whereas States traditionally were required to offer Medicaid only to those low-income individuals who fell within certain "categorically needy" groups (families with dependent children, elderly, blind, disabled, children, and pregnant women), and retained significant flexibility to determine whether and to what extent to cover other low-income individuals, the Act requires States to cover *all* individuals under age 65 with incomes up to 133% of the poverty level, with a 5% "income disregard" provision that effectively raises that threshold to 138%. ACA §§ 2001(a), 2002(a).

By mandating coverage of millions more individuals, including "childless adults who have historically been ineligible for the program," the Act will "necessitat[e] one of the largest enrollment efforts in the program's history." Kaiser Comm'n on Medicaid & the Uninsured, *Expanding Medicaid to Low-Income Childless Adults under Health Reform* 1 (July 2010).[7] Equally important, by tying Medicaid to the near-universal individual mandate and requiring Medicaid coverage for everyone below 138% of the poverty level, the ACA transforms the basic nature of the program. Although the federal government will initially fund 100% of that expansion, by 2017, States will be responsible for 5% of those costs, with that number increasing to 10% by the end of the decade. ACA § 2001(a)(3).

As a reflection of the close connection between the individual mandate and the Medicaid expansion, the ACA also establishes a new "minimum essential coverage" level—a level sufficient to satisfy a recipient's obligations under the individual mandate—that States must provide to all Medicaid recipients. *Id.* §§ 2001(a)(2), 1501(b). That new and onerous requirement eliminates the flexibility States previously enjoyed to determine what level of coverage they could afford to offer to the diverse groups of individuals they chose to cover.

In the shorter term, the Act also locks States into their current eligibility and coverage rates—even those that exceed federal requirements and were voluntary when adopted—through its maintenance-of-effort provision that takes effect immediately (rather than in 2014). Unlike many prior maintenance-of-effort provisions, *see supra*, p. 6 & n.6, the ACA's provision renders maintenance of all "eligibility standards, methodologies, or procedures" currently in place "a condition for receiving *any* Federal payments" until the State has complied with other aspects of the ACA. *Id.* § 2001(b) (emphasis added). As a result, the provision effectively forces States to maintain their current Medicaid spending levels until the massive expansion takes effect in 2014, thereby precluding States from cutting costs now in preparation for the impending spending increase that the expansion will require. In doing so, the provision both eliminates States' traditional discretion to set eligibility thresholds and coverage rates, and essentially penalizes States for having voluntarily extended more generous coverage than Congress required.

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[7] Available at http://www.kff.org/medicaid/upload/8087.pdf.

Finally, the Act requires States not only to pay the costs of care and services for Medicaid enrollees, but also to assume responsibility for providing "the care and services themselves." ACA § 2304. That provision effectively exposes States to liability if the demand for services is greater than the supply of hospitals and doctors willing to provide them.

In conjunction with the individual mandate, the federal government predicts that the Medicaid expansion will increase enrollment by approximately 16 million by the end of the decade. Letter from Douglas Elmendorf, Director, Cong. Budget Office (CBO), to the Hon. Nancy Pelosi, Speaker, U.S. House of Reps. ("CBO Estimate") 9 (Mar. 20, 2010); *see also* CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* (June 16, 2010) (estimating that 6–7 million of those individuals would not enroll in Medicaid without the mandate).[8] To finance that massive expansion, the federal government anticipates that its share of Medicaid spending will increase by $434 billion by 2020. CBO Estimate, Table 4 (Mar. 20, 2010). It further estimates that state spending will increase by at least $20 billion over the same timeframe. CBO Estimate, Table 4 n.c (Mar. 20, 2010). Other estimates suggest that both federal and state costs will be significantly higher. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* 23 (May 2010) (estimating that increased costs could be as high as $532 billion for federal government and $43.2 billion for States).[9]

Unlike in many of its early amendments to Medicaid, Congress did not separate the new coverage requirements and the new funding from the rest of the program and give States the option of continuing to participate in Medicaid while declining to undertake the expansion. If it had, States could have meaningfully assessed whether the newly available funds justified undertaking the onerous new obligations that the Act envisions. Congress instead made the new terms a condition of continued participation in Medicaid, thereby threatening each

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[8] Available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf; and http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf.

[9] Available at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

State with the loss of *all* federal Medicaid funds—for most States, more than a billion dollars per year—unless it adopts the Act's substantial expansion of state obligations under the program.

Indeed, it is worse than that, as the expectation that States will continue to participate in Medicaid is built into requirements for other federal spending programs as well, meaning a State may stand to lose even more than just Medicaid funding if it refuses to accept the ACA's conditions for continued participation. *See, e.g.*, 42 U.S.C. § 602(a)(3) (requiring, as condition of receipt of Temporary Assistance for Needy Families funding, that a State "operate a foster care and adoption assistance program" and ensure that children served by the program "are eligible for medical assistance under the State['s Medicaid] plan"); JA 87 ¶ 12 (declaration from Florida attesting that opting out of Medicaid might jeopardize more than $562 million in annual TANF funding).

While the ACA purports to leave States' participation in Medicaid nominally voluntary, multiple aspects of the Act evince Congress' keen awareness that, in fact, no State will be able to reject its new terms and withdraw from the program. Most obviously, the ACA's individual mandate requires Medicaid-eligible individuals to obtain and maintain insurance. The mandate, like the Medicaid expansion, takes effect in 2014. The Act expressly renders enrollment in Medicaid a means of complying with the individual mandate, but provides no alternative mechanism through which the neediest of individuals might obtain insurance in a State that declined to participate in the newly expanded Medicaid program. *See* ACA § 1501(b), 26 U.S.C.A. § 5000A(f)(1)(A)(ii). The contrast with other components of the ACA is telling. For example, the ACA's "health benefit exchange" provisions, which offer substantial new funding to States willing to implement such exchanges, expressly provide that the federal government will create and operate an exchange if a State declines the federal funding. ACA § 1321(c).

In addition, while the ACA creates significant subsidies for low-income individuals who purchase insurance on the exchanges, those credits and options are available only to those whose income exceeds the federal poverty level, meaning the majority of individuals that Congress presumed would be eligible for Medicaid could not take advantage of the federal subsidies. *See* ACA § 1401(a) (adding § 36B(c)(1)(A) to subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code (IRC) of 1986). Indeed, if an individual applying for insurance through an exchange is eligible for coverage under a State's Medicaid plan, the individual automatically will be enrolled in Medicaid instead, meaning Congress did not envision the exchanges being available to any Medicaid-eligible individuals. ACA § 1413(a). The Act underscores the necessary role that Medicaid plays in determining who is eligible for the new subsidies by including an exception for taxpayers whose income is below the poverty-level eligibility threshold if "the taxpayer is an alien lawfully present in the United States, *but is not eligible for the medicaid program* ... by reason of such alien status." ACA § 1401(a) (adding § 36B(c)(1)(B);

emphasis added). There is no comparable exception for individuals below the threshold who reside in States that decline to participate in Medicaid.

Relatedly, in a provision entitled "State Flexibility to Establish Basic Health Programs for Low-Income Individuals *Not Eligible for Medicaid*," the Act gives States the option of offering approved "standard health plans" to low-income individuals "in lieu of offering such individuals coverage through an Exchange." ACA § 1331(a). But Congress only allows States to offer those plans to individuals under age 65 whose income level exceeds 133% of the poverty level, which are the same qualifications that the ACA establishes for Medicaid eligibility. ACA § 1331(e)(1). Once again, there is an exception for lawful aliens "not eligible for the Medicaid program," but no provision for an individual residing in a State that declines to participate in Medicaid. *Id.*

B. The District Court Proceedings

1. Shortly after Congress passed the ACA, Florida and 12 other States brought this action seeking a declaratory judgment that the Act is unconstitutional. They were subsequently joined by 13 additional States. The States challenged a number of the Act's provisions, including the ACA's expansion of Medicaid on the ground that it is unconstitutionally coercive.

The federal government moved to dismiss the States' challenge, arguing that an offer of federal funding to States under Congress' spending power can never be unconstitutionally coercive. The District Court denied the motion, concluding that, "[i]f the Supreme Court meant what it said in *Dole* and *Steward Machine* ..., there is a line somewhere between mere pressure and impermissible coercion." Pet. App. 463a. Observing that the coerciveness of the ACA "can perhaps be inferred from the fact that Congress does not really anticipate that the states will (or could) drop out of the Medicaid program," Pet. App. 462a, the court concluded that the ACA's requirement that States significantly expand their obligations under Medicaid as a condition of continued receipt of *any* federal Medicaid funding arguably fell on the impermissibly coercive side of that line. Pet. App. 462a–63a.

2. The parties filed cross-motions for summary judgment, and the States provided substantial unrebutted evidence that the ACA coerces them into expanding their Medicaid programs.

As the largely uncontested facts demonstrate, through a combination of mandatory and voluntary expansions of eligibility and coverage, as well as demographic and economic changes over the past half-century, Medicaid has grown exponentially and is now the single largest federal grant-in-aid program to the States. Medicaid presently accounts for more than 40% of all federal funds dispersed to States and approximately 7% of all federal spending. In 2009 alone, States received more than $250 billion in federal Medicaid spending, with most States receiving at least $1 billion, and nearly a third of States receiving more than $5 billion. Henry J. Kaiser Found., *Federal & State Share of Medicaid*

Spending, FY2009 (*"Medicaid Spending, FY2009"*).[10] Federal funding continues to cover no less than 50% and as much as 83% of each State's Medicaid costs, 42 U.S.C. § 1396d(b), and, for the average State, combined state and federal Medicaid spending are the equivalent of approximately 20% of the State's *total* annual budget outlays. Nat'l Ass'n of State Budget Officers, *2008 State Expenditure Report* ("NASBO Report"), Table 5 (*State Spending by Function as a Percent of Total State Expenditures, Fiscal 2008*) (Fall 2009).[11] Moreover, all of those numbers reflect federal and state spending *before* the significant increases envisioned by the ACA.

For example, Florida estimated that, in 2010, providing the same coverage that it provides under Medicaid pre-ACA would cost at least $20 billion and would account for 28% of the State's total annual budget. JA 72 ¶8. Florida estimated that the federal government would cover approximately $13 billion of those costs. Paying for Medicaid without any federal contribution would consume nearly two thirds of Florida's $32 billion in annual tax collections. And the prospect of simply raising taxes to cover the additional costs is not a real one, as the federal government already collects more than *$100 billion* in taxes from Florida's residents. Mem. Supp. Pltfs.' Mot. Summ. J. 33 [R.E. 493].

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[10] Available at http://www.statehealthfacts.org/comparemaptable.jsp?ind=636&cat=4.

[11] Available at http://www.nasbo.org/LinkClick.aspx?fileticket=%2FZWfTvJG8j0%3D&tabid=107&mid=570.

The States also explained why they would not voluntarily accept the ACA's new terms if given a choice. The federal government's own evidence demonstrates that the expansion is expected to cost States at least $20 billion by the end of the decade, *see* CBO Estimate, Table 4 (March 20, 2010), and other estimates are more than double. *See* Kaiser Comm'n, *Medicaid Coverage & Spending*, 23 (estimating that increased costs could be as high as $43.2 billion for States). As the States explained, the significant increase in state spending is to some extent a product of the mandated eligibility expansion, which States will begin to fund in part in 2017. But there are numerous other anticipated costs, including the massive administrative costs of implementing the new federal program,[12] and substantial costs generated by individuals who are presently eligible for but not enrolled in Medicaid, as such individuals will now be forced to enroll in order to comply with the ACA's individual mandate provision, ACA § 1501. *See* CBO, *Key Issues in Analyzing Major Health Insurance Proposals* 12 (Dec. 2008) (estimating that, in 2009, 18% of uninsured were eligible for but not enrolled in Medicaid)[13]; *cf.* CBO Report (June 16, 2010) (estimating that 6–7 million fewer individuals would enroll in Medicaid without the mandate).

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[12] The federal government typically pays only 50% of each State's administrative costs. *See* 42 U.S.C. § 1396b(a)(2)–(5), (7).

[13] Available at http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

Florida estimates that, as a result of the ACA, its share of Medicaid spending will increase by $1 billion annually by the end of the decade. JA 76 ¶ 15. Florida anticipates spending approximately $351 million on its share of the cost for newly eligible program participants who are presently uninsured and $574 million on the currently eligible but unenrolled. JA 76 ¶¶ 17–18. The considerable cost for the latter reflects the fact that, unlike for the newly eligible, Congress has not increased federal funding for those newly enrolled (but previously eligible) by virtue of the ACA's individual mandate. As a result, the States will continue to pay for up to half of the costs generated by the latter group's now-mandatory enrollment. Florida also anticipates spending tens of millions on administrative costs, children who are currently covered by the Children's Health Insurance Program but will shift to Medicaid, and individuals who are presently insured privately but will switch to Medicaid once they become eligible under the ACA's expanded criteria. JA 77 ¶ 20.

Numerous States provided evidence that their situations are equally bleak. *See, e.g.*, JA 116 ¶ 5 (Arizona anticipates additional spending of between $7.5 and $11.6 billion over ten years); JA 125 ¶ 13 (Indiana anticipates additional spending of between $2.6 to $3.1 billion over ten years); JA 135 ¶ 4 (Louisiana anticipates additional spending of approximately $7 billion over ten years); JA 192 (Texas anticipates additional annual spending of $1 billion in 2014–16, $2.1 billion in 2017–19, and $4.4 billion annually thereafter).

Indeed, Medicaid spending has become such a drain on the States that, at the same time that Congress is mandating a significant *increase* in state Medicaid spending, the federal government has recognized that the fiscal stability of States over the next decade will depend largely on their ability to *reduce* the seemingly ever-increasing costs of the program. *See* CBO, *The Long-Term Budget Outlook* 27 (June 2010) ("state governments—which pay a large share of Medicaid's costs and have considerable influence on those costs—will need to reduce spending growth in order to balance their budgets"); U.S. Gov't Accountability Office, *State and Local Governments: Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs* (GAO-10-899) 6 (July 2010) (recommending States immediately and persistently cut Medicaid and other costs "for each and every year going forward equivalent to a 12.3 percent reduction in state and local government current expenditures").[14]

3. Notwithstanding the States' compelling evidence that the ACA leaves them with no choice but to continue to participate in Medicaid under the Act's significantly more onerous conditions, the District Court granted summary judgment to the federal government on the States' coercion claim. Pet. App. 288a. Despite having previously acknowledged that *South Dakota v. Dole*, 483 U.S. 203 (1987), and *Steward Machine Co. v. Davis*, 301

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[14] Available at http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf and http://www.gao.gov/new.items/d10899.pdf.

U.S. 548 (1937), recognize a line between pressure and coercion, the court deemed existing precedent insufficient to support invalidation of spending legislation as unconstitutionally coercive. Pet. App. 287a. Although the court acknowledged "the difficult situation in which the states find themselves," it concluded that "unless and until" this Court "revisit[s] and reconsider[s] its Spending Clause cases," "the states have little recourse to remaining the very junior partner in th[e state-federal] partnership." Pet. App. 287a–88a.

C. The Eleventh Circuit's Decision

The Eleventh Circuit affirmed the District Court's rejection of the States' challenge to the Medicaid expansion. Pet. App. 3a. "[N]ot without serious thought and some hesitation," the court concluded that the States failed to establish coercion. Pet. App. 60a. The court recognized that "many circuits [have] conclu[ded] that the [coercion] doctrine, twice recognized by the Supreme Court, is not a viable defense to Spending Clause legislation." Pet. App. 56a–57a. But it concluded that "[t]o say that the coercion doctrine is not viable or does not exist is to ignore Supreme Court precedent." Pet. App. 59a. It further noted, "[i]f the government is correct that Congress *should* be able to place any and all conditions it wants on the money it gives to the states, then the Supreme Court must be the one to say it." Pet. App. 59a–60a.

Nonetheless, the court rejected the States' coercion claim, offering five factors that it considered "determinative": (1) "Congress reserved the right to make changes to the [Medicaid] program" in 42

U.S.C. § 1304; (2) "the federal government will bear nearly all of the costs associated with the expansion"; (3) "states have plenty of notice ... to decide whether they will continue to participate in Medicaid" before the expansion takes effect in 2014; (4) "states have the power to tax and raise revenue and therefore can create and fund programs of their own if they do not like Congress's terms"; and (5) the Secretary of Health and Human Services has "discretion to withhold all or merely a portion of funding from a noncompliant state" under 42 U.S.C. § 1396c. Pet. App. 60a–62a. The court deemed those factors, "[t]aken together," sufficient to demonstrate that "states have a real choice" whether to continue participating in Medicaid. Pet. App. 63a.

SUMMARY OF ARGUMENT

For the better part of a century, this Court has recognized that the spending power is not "the instrument for total subversion of the governmental powers reserved to the individual states." *United States v. Butler*, 297 U.S. 1, 75 (1936). It could hardly be otherwise. Congress self-evidently could not impose the enormous burdens on the States envisioned by the ACA through direct compulsory legislation. Thus, absent a limit on Congress' ability to impose these same burdens through nominally voluntary exercises of the spending power, all other efforts to constrain Congress and preserve Our Federalism would be for naught. In other words, a judicially enforceable outer limit on Congress' power to use federal tax dollars to coerce States is not just consistent with this Court's precedent; it is a constitutional necessity. And if the ACA's expansion of Medicaid does not surpass that limit, then no Act of Congress ever will.

The proposition that Congress may not use its spending power to coerce the States is a necessary consequence of the principle that "Congress may not simply 'commandee[r] the legislative processes of the States.'" *New York v. United States*, 505 U.S. 144, 161 (1992) (quoting *Hodel v. Va. Surface Mining & Reclamation Ass'n, Inc.*, 452 U.S. 264, 288 (1981)). The Court's renewed focus on the anti-commandeering principle only magnifies the importance of enforcing meaningful limits on the spending power. If Congress were free to use its spending power to coerce States into enforcing the federal government's dictates, then the spending power would become the exception that swallows the anti-commandeering rule.

The coercion doctrine is also an essential corollary of this Court's holding that Congress' spending power "is not limited by the direct grants of legislative power found in the Constitution." *Butler*, 297 U.S. at 66. If Congress could use its spending power only where it could legislate directly, then the rule against coercive uses of the spending power would be needed only to protect States against commandeering. But this Court's recognition of a broader spending power necessarily carries with it the obligation to ensure that Congress does not misuse its spending power to coerce States into bringing their police power to bear on subjects far outside Congress' limited and enumerated powers. For precisely those reasons, the Court has long recognized that a spending power without limits would be tantamount to a federal government without limits, something the Court has never been willing to sanction.

Just as it is clear that there must be a judicially enforceable limit on Congress' spending power, it is equally clear that the ACA exceeds it. While difficult cases will surely arise about when persuasion crosses the line into coercion, this is not one of them. Congress itself recognized that the Medicaid expansion was not truly voluntary when it made that expansion critical to compliance with the individual mandate. Congress created a mandate for all individuals to obtain insurance while providing no alternative to Medicaid for the most needy to obtain the mandated insurance. Simply put, a program that is necessary for the satisfaction of a mandate is not voluntary. It is mandatory.

Congress did not provide an alternative for needy residents of States that opt out of Medicaid because Congress knew that no State could or would opt out. The ACA's contrary approach to two other issues is telling. Because States were given a meaningful choice whether to operate the health benefit exchanges created by the Act, there is a plan B. The federal government will step in if States decline. For Medicaid, there is no fallback. And because States need not provide Medicaid to lawfully present aliens, Congress extended subsidies to lawful aliens below the poverty level. There is no comparable provision for citizens residing in States that opt out of Medicaid, not because Congress was indifferent to whether such citizens were insured, but because Congress understood that it had not given States a real option.

Congress' assumption that States would have no choice but to accept its new terms is unconstitutional, but not unrealistic. The ACA threatens States with the loss of every penny of federal funding under the single largest grant-in-aid program in existence—literally *billions* of dollars each year—if they do not capitulate to Congress' steep new demands. There is no plausible argument that a State could afford to turn down such a massive federal inducement, particularly when doing so would mean assuming the full burden of covering its neediest residents' medical costs, even as billions of federal tax dollars extracted from the State's residents would continue to fill federal coffers to fund Medicaid in the other 49 States.

Because the ACA's expansion of Medicaid is such an extreme and unprecedented abuse of Congress' spending power, this Court can declare the Act's Medicaid provisions unconstitutional without jeopardizing spending legislation writ large. Indeed, there are multiple factors—including Congress' express linkage to an unprecedented mandate, Congress' manifest assumption that no State could or would opt out, the sheer size of the federal inducement at stake, Congress' refusal to limit the new conditions to new funds, and Congress' evident intent to coerce the States—that, taken together, put this coercion challenge in a class of its own. But if the Court were to hold the ACA constitutional in the face of that irrefutable evidence of coercion, the consequences to Our Federalism would be dire indeed. Such a decision would amount to a declaration that Congress' spending power is without bounds, meaning that the only thing "stand[ing] between the remaining essentials of state sovereignty and Congress" would be "the latter's underdeveloped capacity for self-restraint." *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 588 (1985) (O'Connor, J., dissenting).

Congress easily could have designed an act that encouraged rather than forced States to expand their Medicaid programs, much as it did when creating the health benefit exchanges. By making a conscious decision to deprive States of any choice in the matter, Congress has effectively forced this Court's hand. "[T]he federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for [the Court] to admit inability to intervene when one or the other level of Government has tipped the scales too far." *United States v. Lopez*, 514 U.S. 549, 578 (1995) (Kennedy, J., concurring). Because the challenged provisions cannot be upheld without admitting that inability, the Court should hold the Act's Medicaid expansion unconstitutional.

ARGUMENT

I. The Court Should Reaffirm The Vital Constitutional Limitation That Congress May Not Use Its Spending Power Coercively.

"Impermissible interference with state sovereignty is not within the enumerated powers of the National Government." *Bond v. United States*, 131 S. Ct. 2355, 2366 (2011). Accordingly, "[n]o matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the States to regulate." *New*

York, 505 U.S. at 178; *see also Printz v. United States*, 521 U.S. 898, 925 (1997) ("[T]he Federal Government may not compel the States to implement, by legislation or executive action, federal regulatory programs."). Just as Congress may not use its enumerated powers to commandeer the States directly, Congress may not abuse its spending power to coerce the same forbidden result. *See New York*, 505 U.S. at 166 ("Our cases have identified a variety of methods, *short of outright coercion*, by which Congress may urge a State to adopt a legislative program consistent with federal interests." (emphasis added)). Voluntariness is the key to avoiding commandeering: Under any "permissible method of encouraging a State to conform to federal policy choices, the residents of the State retain the ultimate decision as to whether or not the State will comply." *Id.* at 168.

That core limitation on Congress' power is a necessary reflection of the fact that "the preservation of the States, and the maintenance of their governments, are as much within the design and care of the Constitution as the preservation of the Union and the maintenance of the National government." *Texas v. White*, 74 U.S. 700, 725 (1868). Because "our federal system preserves the integrity, dignity, and residual sovereignty of the States," *Bond*, 131 S. Ct. at 2364, States must retain the ability to make meaningful choices about what policies to adopt and how to implement them. Only if States "remain independent and autonomous within their proper sphere of authority," *Printz*, 521 U.S. at 928, can "[f]ederalism secure[] the freedom of the individual." *Bond*, 131 S. Ct. at 2364; *see also*

Gregory v. Ashcroft, 501 U.S. 452, 459 (1991) ("In the tension between federal and state power lies the promise of liberty."). When Congress "issu[es] an unavoidable command" rather than "offer[ing] the States a legitimate choice," *New York*, 505 U.S. at 185, neither federalism nor liberty can thrive.

This Court has long recognized that limits on Congress' power to intrude on state sovereignty necessitate judicially enforceable limits on the spending power. "If, in lieu of compulsory regulation of subjects within the states' reserved jurisdiction, which is prohibited, the Congress could invoke the taxing and spending power as a means to accomplish the same end, clause 1 of section 8 of article 1 would become the instrument for total subversion of the governmental powers reserved to the individual states." *Butler*, 297 U.S. at 75. The Court's renewed insistence that Congress respect the integrity, dignity, and residual sovereignty of the States, including the prohibition on commandeering the States, only underscores the need for judicially enforceable limits on the spending power. If Congress remains free to go beyond voluntary initiatives of cooperative federalism to commandeer States by using the spending power to issue offers that cannot be refused, then anti-commandeering principles are merely parchment barriers.

To avoid that unacceptable result, the Court has imposed meaningful limits on Congress' exercise of its spending power, drawing from well-settled contract law principles. *See Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) ("[L]egislation enacted pursuant to the spending power is much in the nature of a contract.").

The constraint that Congress may not use its spending power coercively is both a constitutional necessity and a straightforward application of those principles. "Just as a valid contract requires offer and acceptance of its terms, '[t]he legitimacy of Congress' power to legislate under the spending power ... rests on whether the [recipient] *voluntarily* and knowingly accepts the terms of the 'contract.'" *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (quoting *Pennhurst*, 451 U.S. at 17; emphasis added); *see also Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (same). In other words, valid acceptance must be voluntary "not merely in theory but in fact." *Dole*, 483 U.S. at 211.

Because acceptance cannot be voluntary when the federal government abuses its powers (including the taxing power to raise revenue from residents of the States) to eliminate the element of choice, the Court has long recognized that an exercise of Congress' spending power would violate the Constitution if it were "so coercive as to pass the point at which 'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 590); *see also Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999); *Sabri v. United States*, 541 U.S. 600, 608 (2004). Nowhere is that more obvious than in legislation like the ACA that compels the States to act in ways that Congress could not compel directly. In that context, spending power legislation that crosses the line into compulsion self-evidently violates the Constitution.

It could hardly be otherwise. The coercion doctrine is as essential to preservation of the

Constitution's enumeration of limited federal powers as it is to the preservation of the integrity, dignity, and residual sovereignty of the States. From the earliest days of our Nation, the Court has recognized that "[t]he powers of the [federal] legislature are defined, and limited." *Marbury v. Madison*, 5 U.S. 137, 176 (1803); *see also McCulloch v. Maryland*, 17 U.S. 316, 405 (1819) ("The principle, that [Congress] can exercise only the powers granted to it ... is now universally admitted."). That enumeration of limited powers "presupposes something not enumerated." *Gibbons v. Ogden*, 22 U.S. 1, 74 (1824). An unlimited spending power could not be reconciled with those fundamental principles.

Although the federal government will protest any effort to impose meaningful limits on the spending power, it has no basis to do so. Those limits are a necessary consequence of the federal government's successful effort to broaden the spending power. If the spending power were limited to spending on items within Congress' enumerated regulatory powers, then the Court would need to police only spending legislation that impermissibly commandeered the States or violated other affirmative limits on Congress' power. Yet this Court long ago accepted the federal government's invitation to view the spending power as not so limited. *See Butler*, 297 U.S. at 66; *Dole*, 483 U.S. at 207.

Thus, having accepted the federal government's invitation to view the spending power more broadly, it is incumbent on this Court to fashion judicially enforceable outer limits on the power that will ensure preservation of the federal balance and the

Constitution's broad reservation of powers to the States. *See* U.S. Const., amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."). Absent such enforceable limits, the spending power "has the potential to obliterate distinctions between national and local spheres of interest and power by permitting the Federal Government to set policy in the most sensitive areas of traditional state concern, areas which otherwise would lie outside its reach." *Davis v. Monroe Cnty. Bd. of Educ.*, 526 U.S. 629, 654–55 (1999) (Kennedy, J., dissenting).

Indeed, an unlimited spending power would be just as dangerous as a plenary regulatory authority and just as inconsistent with our Constitution's basic design. Without the limitation that Congress may not exercise its spending power coercively, Congress could use that power to compel the States to use their police power to reach any issue, no matter how far removed from Congress' limited and enumerated powers. The argument against recognizing a judicially enforceable distinction between coercion and persuasion therefore reduces to the untenable conclusion that, "though the makers of the Constitution, in erecting the federal government, intended sedulously to limit and define its powers, … they nevertheless by a single clause gave power to the Congress to" regulate all fields reserved to the States, "subject to no restrictions save such as are self-imposed." *Butler*, 297 U.S. at 78. "The argument, when seen in its true character and in the light of its inevitable results, must be rejected." *Id.*

That the line between coercion and persuasion may not be bright is no reason to abandon all efforts to police the line given its importance in preserving our constitutional balance. This Court is "often called upon to resolve questions of constitutional law not susceptible to the mechanical application of bright and clear lines," *Lopez*, 514 U.S. at 579 (Kennedy, J., concurring), particularly where conflicts between federal and state power arise. Notwithstanding the difficulty of resolving those weighty questions, the Court has not hesitated to do so to preserve the Constitution's essential structure. *See, e.g.*, *id.*; *City of Boerne v. Flores*, 521 U.S. 507, 519–20 (1997) ("While the line between measures that remedy or prevent unconstitutional actions and measures that make a substantive change in the governing law is not easy to discern ... the distinction exists and must be observed."); *Butler*, 297 U.S. at 67 ("[D]espite the breadth of the legislative discretion [under the spending power], our duty to hear and to render judgment remains. If the statute plainly violates the stated principle of the Constitution we must so declare.").

Indeed, "the task of ascertaining the constitutional line between federal and state power has given rise to many of the Court's most difficult and celebrated cases." *New York*, 505 U.S. at 155. As the Court's consistent efforts to ascertain that line reflect, "the federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for [the Court] to admit inability to intervene when one or the other level of Government has tipped the scales too far." *Lopez*, 514 U.S. at 578 (Kennedy, J., concurring); *see* *also Garcia*, 469 U.S. at 581 (O'Connor, J., dissenting) ("If federalism so conceived and so carefully cultivated by the Framers of our Constitution is to remain meaningful, this Court cannot abdicate its constitutional responsibility to oversee the Federal Government's compliance with its duty to respect the legitimate interests of the States." (citation omitted)).

To be sure, "so long as Congress' authority is limited to those powers enumerated in the Constitution, and so long as those enumerated powers are interpreted as having judicially enforceable limits, congressional legislation ... always will engender 'legal uncertainty.'" *Lopez*, 514 U.S. at 566; *see also McCulloch*, 17 U.S. at 405 ("[T]he question respecting the extent of the powers actually granted, is perpetually arising, and will probably continue to arise, so long as our system shall exist."). But "[a]ny possible benefit from eliminating this 'legal uncertainty' would be at the expense of the Constitution's system of enumerated powers" and the integrity, dignity, and residual sovereignty of the States that it preserves. *Lopez*, 514 U.S. at 566; *cf. United States v. Morrison*, 529 U.S. 598, 620 (2000) (limitations on Congress' section 5 authority "are necessary to prevent the Fourteenth Amendment from obliterating the Framers' carefully crafted balance of power between the States and the National Government").

That is nowhere more true than in the spending power context. If the federal government were correct that there are no limits on Congress' ability to use its spending power to coerce the States, then "constitutional guarantees, so carefully safeguarded against direct assault, [would be] open to destruction by the indirect, but no less effective, process of requiring a surrender, which, though in form voluntary, in fact lacks none of the elements of compulsion." *Frost & Frost Trucking Co. v. R.R. Comm'n*, 271 U.S. 583, 593 (1926); *see also Butler*, 297 U.S. at 71 ("The power to confer or withhold unlimited benefits is the power to coerce or destroy.").

This Court long ago confirmed that the judiciary has an obligation to ensure that the spending power does not become that kind of "instrument for total subversion of the governmental powers reserved to the individual states." *Id.* at 75. In keeping with that obligation, although the Court has acknowledged the difficulty inherent in determining "the point at which pressure turns into compulsion," *Steward Machine*, 301 U.S. at 590, it has steadfastly refused to abandon the enterprise. *See id.* at 591 ("We do not fix the outermost line. Enough for present purposes that wherever the line may be, this statute is within it."); *Dole*, 483 U.S. at 211 (reaffirming coercion doctrine's existence); *Fla. Prepaid*, 527 U.S. at 687 (same). To do so now would be tantamount to abandoning the very framework of our system of constitutional governance.

II. The ACA's Amendments To Medicaid Are Unconstitutionally Coercive.

While this Court will surely confront difficult cases concerning the "point at which pressure turns into compulsion," *Steward Machine*, 301 U.S. at 590, this is not one of them. Indeed, if the ACA does not cross the line, no Act of Congress ever will. Here, Congress answered the coercion question itself by tying Medicaid to the individual mandate and premising its comprehensive health insurance reform scheme on the understanding that States had no realistic option but to expand Medicaid. The individual mandate gives low-income individuals no choice but to obtain insurance. And the Act provides no means for those individuals to obtain such insurance save Medicaid. A program necessary to satisfy a mandate cannot be understood as anything other than mandatory.

Congress itself recognized that States have no more choice to opt out of Medicaid than individuals have to opt out of the mandate. Indeed, States have less choice. While some individuals are exempt from the penalties designed to enforce the mandate, no State is exempt from the massive penalty—the loss of the entirety of funding under the single largest grant-in-aid programs for the States—and so Congress did not even contemplate the possibility of a State opting out of Medicaid. Elsewhere, where Congress provided States with meaningful choices, it provided a plan B. Not so with Medicaid. Congress provided no fallback because Congress itself recognized it was making States an offer they could not refuse.

A. The ACA Is Premised on the Understanding that It Forces States to Expand Medicaid.

The best evidence of the ACA's coercive effect is the ACA itself. "[I]t would make little sense for Congress to" devise a comprehensive scheme for "near-universal" health insurance coverage that "leave[s] millions of the country's poorest citizens without medical coverage." Pet. App. 463a. It would make even less sense to issue an unprecedented command that virtually all individuals obtain health insurance and then provide no means by which millions of individuals could obtain the insurance necessary to satisfy that mandate. Yet that is exactly what Congress would have done if States' acceptance of the Medicaid expansion were truly voluntarily, as the ACA provides no means *other than Medicaid* through which the Nation's neediest residents might obtain insurance and comply with the mandate. Fear not. Congress' failure to provide an alternative to Medicaid was a product of neither imprudence nor oversight. Congress did not provide an alternative because it understood that it had not given States any meaningful choice to opt out. In reality, the States' "acceptance" of the Medicaid conditions is no less mandatory than the individual mandate itself.

The link between the Medicaid expansion and the need for all individuals, including low-income individuals, to obtain insurance is undeniable. They share an effective date, and Congress specifically recognized that Medicaid coverage satisfies an individual obligation under the mandate. *See* ACA § 1501(b), 26 U.S.C.A. § 5000A(f)(1)(A)(ii). Indeed, the ACA revolutionizes Medicaid to make it serve the mandate and the ACA's broader goal of near-universal coverage. Congress transformed Medicaid from a program designed to provide insurance to certain discrete categories of the needy, with substantial state discretion as to eligibility and the level of coverage, into one designed to provide a minimum level of coverage to every needy citizen. In sum, Congress transformed Medicaid into a mandatory program specifically designed to supply insurance to the low-income individuals forced to obtain coverage by the ACA and its individual mandate. Congress provided no fallback for the neediest to obtain the insurance demanded by the ACA because a State's failure to participate in Medicaid was not just impractical, but inconceivable to the drafters of the ACA.

That lack of any contingency plan stands in stark contrast to other provisions of the Act in which Congress gave States a meaningful option and expressly accounted for the possibility that States might decline the federal blandishments. Most prominently, in providing for the creation of "health benefit exchanges" in each State, Congress authorized the federal government to establish and operate those exchanges in any State that chooses to forgo federal funding to do so itself. By deeming it unnecessary to acknowledge even the *possibility* that States might exit the Medicaid program rather than comply with the ACA, Congress confirmed its understanding that States quite literally could not afford to lose the billions of dollars in federal funding that the ACA puts at stake. *See* Pet. App. 462a ("Congress does not really anticipate that the states will (or could) drop out of the Medicaid program").[15]

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[15] The Court of Appeals erroneously assumed that the ACA does not require States to choose between adopting Congress' new conditions or opting out of Medicaid, and instead leaves the Secretary with discretion to allow States to continue

Other provisions of the ACA reflect that same understanding—namely, that State participation in Medicaid was not a matter open to choice. For example, Congress created tax subsidies for low-income individuals who purchase insurance, but it made those subsidies available only to individuals above the poverty level, meaning that most Medicaid recipients are not eligible for the new subsidies. *See supra*, pp. 12–13. As that limitation reflects, Congress saw no need to extend the subsidies to those below the poverty level because it was confident that Medicaid would continue to satisfy their insurance needs in every State. Indeed, Congress confirmed that its assumption that Medicaid coverage would be available explains its failure to extend eligibility to those below the poverty level when it crafted an exception to the income limit for individuals who are "*not eligible for the medicaid program* ... by reason of [their] alien status." ACA § 1401(a) (adding § 36B(c)(1)(B)). No comparable exception was made for citizens living in States that opt out of Medicaid because Congress knew that was not a realistic option.

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participating in Medicaid without abiding by the ACA's new terms. *See* Pet. App. 62a (citing 42 U.S.C. § 1396c). The federal government does not defend that misconception. To the contrary, the federal government has conceded before this Court, as it has throughout this litigation, that the "categories of individuals to whom state programs must provide medical assistance, as well as the kinds of medical care and services the program must cover," remain requirements with which States must comply "[t]o be eligible for federal funds." Govt.'s Response Pets. Cert. 11.

Congress' understanding that the ACA would coerce States into expanding Medicaid is also reflected by a comparison with past amendments to Medicaid. For example, back in 1972, when Medicaid had not yet swelled to the massive funding levels of today, Congress chose *not* to make extension of coverage to all SSI recipients a condition of continued program participation because it "feared that [some] States would withdraw from the cooperative Medicaid program rather than expand their Medicaid coverage." *Schweiker*, 453 U.S. at 38. To avoid that possibility, which was still a very real one in Medicaid's early years, Congress crafted an alternative for States that wanted to continue to participate at existing coverage levels. *See id.* at 38–39. The ACA demonstrates that Congress has overcome its fears and now legislates with confident knowledge that if it places the entirety of Medicaid funding at risk, States no longer have the ability to "withdraw from the cooperative Medicaid program rather than expand their Medicaid coverage."

Other Medicaid amendments also evince Congress' grasp of the difference between persuasion and coercion and its purposeful decision to bring the latter to bear here. For example, at various points throughout the program's existence, Congress has offered *additional* funds to States that agreed to take on new obligations, rather than threatening to *withhold* all funds from States that were unwilling or unable to do so. *See, e.g., supra*, p. 6 & n.6. Congress could have done exactly that here, by making coverage of newly eligible individuals a condition of receiving only *new* funding for those individuals, not of receiving *any* Medicaid funding—

nearly 40% of all funds the States receive from the federal government even before the massive expansion worked by the ACA.

To be sure, limiting the conditions to the new funding stream would have given States a meaningful choice whether to expand the Medicaid programs. But Congress did not want to give States a meaningful choice and so conditioned the entirety of Medicaid funding on the transformation of Medicaid. Because Congress knew that putting all Medicaid funding at risk would deprive States of any say in the matter, it provided no contingency plan for that inconceivable possibility. That approach may be far more efficient from Congress' perspective (indeed, every bit as efficient as legislation that explicitly compelled the States to act), but it is not an option Congress enjoys under the Constitution. Efficient or not, the Constitution "simply does not give Congress the authority to require the States to regulate." *New York*, 505 U.S. at 178.

In short, as Congress' own understanding of the ACA's operation reflects, while the line between persuasion and coercion may in other instances be "a question of degree," *Steward Machine*, 301 U.S. at 590, in this case it is not. "[T]he point of coercion is automatically passed," *Florida Prepaid*, 527 U.S. at 687, when Congress premises a comprehensive regulatory scheme on the understanding that States have no choice but to participate. "In such circumstances, if in no others, inducement or persuasion" necessarily goes "beyond the bounds of power." *Steward Machine*, 301 U.S. at 591. That the ACA rests on Congress' eminently reasonable assumption that no State could afford to withdraw from Medicaid—indeed, Congress has not even established any mechanism by which a State might do so—is all the proof the Court should need to find the Act unconstitutionally coercive.

B. The ACA's Coerciveness Is Confirmed by Medicaid's Sheer Size and Congress' Attachment of New Terms to Preexisting Funding.

The ACA threatens States with loss of *all* of their federal Medicaid funding if they do not capitulate to Congress' mandate that they dramatically expand their obligations under the program. The coerciveness of that demand is self-evident, as the sheer size of the federal inducement at stake puts this spending legislation in a class of one. Medicaid is already the single largest federal grant-in-aid program, accounting for a staggering 40% of all federal funds distributed to States and nearly 7% of *total* federal spending. In 2009 alone, most States received well over $1 billion in federal Medicaid funding—nearly a third of States received more than *$5 billion*. *See* Kaiser Found., *Medicaid Spending, FY2009*. The average State spends at least 20% of its *entire* budget on Medicaid, and federal funds cover no less than half (and oftentimes more) of each State's costs. NASBO Report, Table 5. And the ACA promises a massive expansion of the program and the amount of federal dollars devoted to it. No State could plausibly afford to forfeit all federal funding under a program of that unparalleled magnitude.

The coerciveness of the ACA is reflected not just in the sheer size of the federal inducement at stake, but in the fact that much of that inducement consists of pre-existing Medicaid funding. When Congress makes new funds available, it obviously has substantial discretion to determine how those new funds are spent. Even then, the need to enforce meaningful limits on Congress' enumerated powers and the obvious reality that Congress is spending funds raised by taxes imposed on in-State taxpayers, thereby limiting States' ability to raise state taxes to replace those funds, demand some scrutiny. But when Congress seeks to condition not just newly available funds but pre-existing funding on a State's agreement to expand a program, the need for close scrutiny is heightened. The conscious decision to put at risk pre-existing funding streams for programs with 100% state participation and built-in constituencies means that Congress is not just imposing reasonable conditions on how funds may be spent, but using each State's—and each State's residents'—dependency on existing funding streams to coerce compliance with new conditions. And when both the pre-existing funding and the newly available funding are of unprecedented size, the coercion concerns are truly at their zenith.

That is precisely the situation here. By placing new conditions on continued receipt of all existing Medicaid funding (as well as on billions of dollars in new funding), Congress made clear that the ACA does not simply (or even primarily) fix the terms on which the substantial new funds it provides may be spent. It instead uses States' past decisions to participate in Medicaid to compel them to adopt, enforce, and even help fund a transformative program expansion, something Congress could not otherwise do without running afoul of the commandeering doctrine. *See Butler*, 297 U.S. at 73 ("There is an obvious difference between a statute stating the conditions upon which moneys shall be expended and one effective only upon assumption of a contractual obligation to submit to a regulation which otherwise could not be enforced."). In other words, the ACA exploits each State's dependence on existing Medicaid funding—funding largely composed of federal tax dollars collected from States' residents who have come to depend on the return of those tax dollars to help fund critical medical care—to force States to continue participating in Medicaid under significantly altered terms.

Both the federal government and the Court of Appeals attempt to minimize the coerciveness of Congress' decision to put the entirety of Medicaid funding at risk by contending that Congress "reserved ... the 'right to alter, amend, or repeal'" any aspect of the program. Pet. App. 60a (quoting 42 U.S.C. § 1304). But that both overstates what Congress reserved and confuses foreseeability and coercion. As to the former, States did not enter into Medicaid with notice—"clear" or otherwise, *see Pennhurst*, 451 U.S. at 17—that they were ceding to Congress the power to expand the program unilaterally and coercively. *See* 11th Cir. Amicus Br. for James A. Blumstein. States surely understood that by agreeing to participate in what was, at the time, a cooperative federal program, they did not obtain any vested right that the program would continue indefinitely or upon the same terms. But they by no means bargained away their right to insist that Congress not act coercively by conditioning continuing participation in the unaltered aspects of the program on their "agreement" to expand the program massively.

What is more, even if Congress could reserve to itself the power to unilaterally and coercively alter spending programs, Congress did not do so here. Section 1304 merely reserves to Congress the right to "make such alterations and amendments [to Medicaid] *as come within the just scope of legislative power.*" *Bowen v. Pub. Agencies Opposed to Soc. Sec. Entrapment*, 477 U.S. 41, 53 (1986) (emphasis added). It is not "within the just scope of" Congress' power to use past decisions to participate in Medicaid, and the entrenched dependence of existing constituencies that those decisions have generated, to hold States hostage to Congress' later demands.

In all events, even an express statement by Congress that it reserved the right to convert Medicaid from a voluntary program to a compulsory one would not deprive States of the opportunity to object when the conversion occurred. Coercion and forseeability are not the same things. A classic form of coercion is the threatening of future foreseeable harm. The salient point is not whether States had any warning that Congress might exploit their dependence on Medicaid funding to coerce compliance with a massive expansion of the program, but whether Congress' coercive action is permissible. It is not.

C. States Have No Realistic Alternative to Continued Participation in Medicaid.

The coerciveness of the ACA is not diminished by the observation that States "have the power to tax and raise revenue." Pet. App. 62a. Indeed, the difficulty of declining massive funding streams that result from federal taxation that in turn saps the practical ability of States to raise their own revenues is part and parcel of the coerciveness of the ACA.

Federal spending is not a product of Congress' "generosity," *see* Govt.'s Response Pets. Cert. 15, in disbursing funds that materialize out of thin air. Federal funding is overwhelmingly composed of tax dollars collected from the States' own residents. Accordingly, when the federal government makes conditional funding offers to the States, it is "impos[ing] its policy preferences upon the States by placing conditions upon the return of revenues that were collected from the States' citizenry in the first place." *Va. Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997). Were a State to refuse to comply with Congress' conditions, "federal taxpayers in [that State] would be deprived of the benefits of a return from the federal government to the state of a significant amount of the federal tax monies collected." *Jim C. v. United States*, 235 F.3d 1079, 1083 (8th Cir. 2000) (Bowman, J., dissenting). The larger the amount of the funds conditioned, the less realistic the State's purported option of turning down the funds. Its practical ability to ask residents, already taxed by the federal government to provide health insurance elsewhere, to contribute additional taxes to supplant the declined federal program is all but nil.

That point is critical. The analysis might be different if the massive amount of money used to induce the States to "accept" conditions came from some place other than taxpayers in the States. But there is no such pot of money. If a State were to withdraw from Medicaid, "federal funds taken from [its] citizens via taxation that used to flow back into the states from Washington, D.C., would instead be diverted to the states that have agreed to continue participating in the program." Pet. App. 463a. Because the Medicaid funds used to induce the States come from their own taxpayers, the "option" of declining billions of dollars of federal funds and paying for medical care for the indigent through new taxes on in-State taxpayers who are already funding that care in the other 49 States is illusory. The choice given States is the equivalent of that offered by a pickpocket who takes a wallet and gives the true owner the "option" of agreeing to certain conditions to get the wallet back or having it given to a stranger.

To put the problem in concrete terms, in 2009, Florida collected less than $32 billion in taxes from its residents. *See* Fed'n of Tax Adm'rs, *2009 State Tax Revenue.*[16] That same year, the federal government collected a staggering *$110 billion* from Florida residents, approximately 10% of which—more than $10 billion—was returned to Florida in the form of Medicaid funding. *See* Kaiser Found., *Medicaid Spending, FY2009*; Mem. Supp. Pltfs.' Mot. Summ. J. 33 [R.E. 493]. Given the sheer size of Medicaid, Florida has no practical ability to inform its citizens that it will be declining that $10 billion and raising state taxes by 30% as a result, while the federal tax burden remains the same. That is even more true given that those numbers are based on the assumption that funding its own alternative to Medicaid would cost Florida exactly the same amount as Medicaid, a rather unrealistic assumption in the short run given the substantial costs of getting a substitute program up and running. And those numbers do not account for the reality that the ACA will expand federal Medicaid spending by another $434 billion over the next decade, such that the burden on Florida's residents to fund health insurance in the other 49 States would be much greater going forward. *See supra*, p. 10. In short, the suggestion of simply raising taxes to fund an alternative to Medicaid is not "merely a hard choice," *Oklahoma v. Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981); it is no choice at all.

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[16] Available at www.taxadmin.org/fta/rate/09taxbur.html.

Precisely because States have no real choice in the matter, it is also irrelevant that Congress has given States what the Court of Appeals characterized as "plenty of notice" before many of the ACA's terms will take effect. Pet. App. 62a.[17] No amount of notice will render a coercive choice any less coercive. An extortionist who provides ample forewarning of his collection schedule may thereby maximize collections, but he does not lessen the extortionate nature of his demands. Whether Congress gives States one year or ten years before the ACA's new conditions take effect, States have no realistic alternative to continued participation in Congress' dramatically expanded form of Medicaid.

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[17] Even assuming a mere four years constitutes "plenty of notice" for a State to raise billions of dollars to create an alternative to Medicaid, the States did not receive even that much notice as to all of the Act's terms. For example, the mandatory maintenance-of-effort provision *immediately* locked States into terms that States put in place when whether to do so (and whether to continue to do so) was voluntary. *See* ACA § 2001(b); *cf. Pennhurst*, 451 U.S. at 25 (Congress may not "surprise[] participating States with post acceptance or 'retroactive' conditions").

Tellingly, the federal government has not made any real attempt to demonstrate that States could afford to turn down billions of dollars in Medicaid funding and go it alone. The federal government has instead attempted to change the subject. Like the Court of Appeals, *see* Pet. App. 61a, it places great emphasis on the fact that the States (at least initially) will pay only a small portion of the costs generated by the ACA's expansion. Even assuming the federal government were correct in its assessment of how much the ACA will cost the States (and the States vehemently dispute the federal government's projections), that argument reflects a fundamental misunderstanding of the relevant legal principles. Coercion is measured by how much a State stands to lose if it *rejects* Congress' terms, not by how much it stands to lose if it *accepts* them. That is why "the coercion inquiry focuses on the financial inducement offered by Congress," *Madison v. Virginia*, 474 F.3d 118, 128 (4th Cir. 2006) (internal quotation marks omitted), not how much money a State is "being coerced into spending," Pet. App. 61a–62a. When a thief produces a loaded gun and demands, "your money or your life," that demand is equally coercive whether the victim is carrying $5 or $500. Either way, given the alternative, "[t]he asserted power of choice is illusory." *Butler*, 297 U.S. at 71.

Indeed, given the practical effect on a State's ability to tax, the fact that the federal government's inducement is substantial only exacerbates its coerciveness. If the ACA offered States double the amount of their Medicaid expenditures if they would accept the new conditions, that double or nothing offer (with in-State tax dollars flowing out either way) would make the offer harder, not easier, to refuse, and would render any notion of meaningful choice that much more illusory.

But that power of choice is what the coercion doctrine is designed to protect. "It is an essential attribute of the States' retained sovereignty that they remain independent and autonomous within their proper sphere of authority." *Printz*, 521 U.S. at 928. The coercion doctrine ensures that independence and autonomy by safeguarding a *State*'s prerogative to determine whether Congress is offering a good deal or a bad one; Congress' insistence that it is the former cannot deprive States of that right. *See New York*, 505 U.S. at 168 ("by any ... permissible method of encouraging a State to conform to federal policy choices, the residents of the State retain the ultimate decision as to whether or not the State will comply"). If anything, that Congress expects to increase federal Medicaid spending by ***$434 billion*** over the next decade therefore renders the ACA more coercive, not less, as States face the loss of even more federal tax dollars if they do not capitulate to Congress' new demands.

In all events, were Congress correct that the ACA is such an obvious bargain for the States, Congress would lose nothing by abandoning its coercive tactics, as States surely would accept the new federal funds and conditions even without the threatened loss of billions in existing funding. Congress' unwillingness to give States that choice confirms its grasp of the dire circumstances States face. At a time when the federal government itself has recognized that States must significantly *decrease* Medicaid spending to return to fiscal stability, *see supra*, p. 18, Congress is effectively mandating at least a ***$20 billion*** increase in States' Medicaid spending over the next decade, with that amount only expected to continue rising thereafter. It is no wonder Congress will not give States—an unprecedented majority of which have joined this brief—a meaningful choice in the matter.

D. This Court's Precedents Support the Conclusion that the ACA Is Coercive.

This Court's decisions in *Steward Machine* and *Dole* also underscore the invalidity of the ACA's expansion of Medicaid. Although neither case held the challenged spending program unconstitutionally coercive, neither case presented a coercion claim of this magnitude. Nor did either present the straightforward case of a statute in which Congress itself confirmed that States had no choice but to comply. Nonetheless, the reasoning of both cases is directly on point.

Steward Machine involved a challenge to a new provision of the Social Security Act that imposed a federal unemployment tax upon certain employers but allowed a deduction of up to 90% if a State imposed its own tax to create an unemployment compensation program that satisfied certain federal requirements. *See Steward Machine*, 301 U.S. at

574. Thus, unlike in this case, where Congress provided no alternative to state compliance with Congress' conditions, in *Steward Machine*, Congress had provided a federal default option but given States a clear option to adopt an alternative. Not every State adopted the 90% option, but the State in question voluntarily did, and the coercion challenge that followed was brought by a private employer and resisted by the State, a factor upon which the Court placed great weight in finding the scheme non-coercive. *See id.* at 589 ("Even now [the State] does not offer a suggestion that in passing the unemployment law she was affected by duress.").

To be sure, "[w]here Congress exceeds its authority relative to the States ... the departure from the constitutional plan cannot be ratified by the 'consent' of state officials." *New York*, 505 U.S. at 182. And the mere fact that some States are willing to accept Congress' terms is not enough, standing alone, to demonstrate that Congress has left them any other choice. That said, when no State even "suggest[s]" spending legislation is coercive, *Steward Machine*, 301 U.S. at 589, that is certainly a strong indication that States' acceptance of federal conditions was voluntary "not merely in theory but in fact." *Dole*, 483 U.S. at 211. That could not be farther from the case in this unprecedented action, in which more than half the Nation's States have joined forces to attest that Congress is forcing them to govern according to federal dictates that they would reject if given a meaningful choice.

A proper understanding of the Court's explanation for rejecting the claim presented in *Steward Machine* requires appreciation of the unusual context of a coercion claim not supported by a State. When the Court cautioned that "to hold that motive or temptation is equivalent to coercion is to plunge the law into endless difficulties," *Steward Machine*, 301 U.S. at 589–90, it was rejecting the argument that spending legislation is *always* coercive—even when the States and the federal government are in agreement that it is not, and even when, as was the case there, other States had demonstrated their ability to reject federal funds by doing just that. *See id.* at 588 & n.9. In rejecting the extreme position that spending legislation is always coercive, the Court was hardly adopting the converse position that spending legislation can *never* be coercive. That could not be clearer from the Court's ultimate holding that, "in [these] circumstances, *if in no others*," coercion was not established, and its insistence that "[d]efinition more precise must abide the wisdom of the future." *Id.* at 591 (emphasis added); *see also id.* at 590 ("In ruling as we do, we leave many questions open."); *Dole*, 483 U.S. at 209 (asserting that *Steward Machine* "recognized" the existence of the coercion doctrine).

More fundamentally, *Steward Machine* is premised on an understanding of the spending power that is wholly inconsistent with the federal government's arguments in this case. When the Court rejected the coercion challenge presented in *Steward Machine*, it made clear its belief and expectation that, if States chose not to take advantage of the option of offsetting the federal unemployment tax with a tax of their own, the federal government would use the money collected through the federal tax to provide residents of such

States with some form of *federal* assistance. *See* 301 U.S. at 588–89; *see also id.* at 590 (characterizing State as having "chose[n] to have relief administered under laws of her own making, ... *instead of under federal laws*" (emphasis added)). While the Court recognized that Congress was not expressly obligated to spend the tax receipts in any specific manner, *see id.* at 589, it did not so much as hint that Congress could impose the federal tax and do nothing for the unemployed in States that opted out. More to the point, the Court did not sanction a regime in which the federal tax dollars would be dedicated exclusively to supplementing state unemployment insurance programs in the States that opted in. If Congress had passed such a statute it would be analogous to the ACA, but it is impossible to think that the *Steward Machine* Court would have blessed that statute as constitutional.

By insisting that the ACA is *not* coercive because States have the "option" of forfeiting billions in federal Medicaid funding and assuming the full obligation of funding medical assistance for millions of their neediest residents while in-State federal tax dollars fund programs elsewhere, the federal government and the Court of Appeals turn *Steward Machine* on its head. *See* Pet. App. 62a. It is one thing for the Court to reject a coercion claim under the assumption that States may choose between accepting federal funds and accompanying conditions, or allowing the federal government to use equivalent funds to equivalent ends. *See Hodel*, 452 U.S. at 264. Such a program is akin to the real choice that the ACA offers States to create exchanges or have the federal government do so. It is quite another to reject a coercion claim when the federal government not only insists that a State's sole alternative is for its residents to forfeit federal tax dollars entirely, but premises its whole regulatory scheme on the assumption that no State could possibly afford to do so. That is the non-choice offered States by the ACA when it comes to Medicaid.

In that respect, this case is more analogous to *New York* than to *Steward Machine*. The take-title provision held unconstitutional in *New York* interfered with state sovereignty by ordering States either to regulate radioactive waste pursuant to Congress' dictates or to assume full liability for waste generated within their borders. *See New York*, 505 U.S. at 174–75. The ACA interferes with state sovereignty by effectively ordering States either to regulate medical assistance for the needy according to Congress' dictates or to assume full responsibility for all medical assistance to the needy themselves. What is more, it does so while the federal government increases the costs by mandating that virtually everyone, including the neediest, maintain health insurance, while at the same time excluding the very neediest from federal subsidies designed to make that mandate more affordable. Once again, the individual mandate and the absence of any federal alternative for the very neediest belie the "voluntary" nature of the "option" given to States when it comes to Medicaid. Here, as in *New York*, "Congress has crossed the line distinguishing encouragement from coercion." *Id.* at 175. If anything, the coerciveness is even more profound in the ACA because States are, for practical purposes, *incapable* of assuming that financial burden so long as Congress continues to collect billions of tax dollars from their residents to fund a massive spending program for which they will no longer be eligible.

Congress' decision to tie continued receipt of *any* Medicaid funding to acceptance of the ACA's new conditions also readily distinguishes the States' claim from the coercion claim rejected in *Dole*. There, Congress conditioned only 5% of federal highway funding—for South Dakota, approximately $4.2 million—on a State's agreement to establish a minimum drinking age of 21. *See Dole*, 483 U.S. at 211. That "relatively mild encouragement," *id.*, pales in comparison to Congress' threat to withhold the entirety of the single largest source of federal funding if States do not accept the ACA's terms. Indeed, many States received more than *1000 times* that amount in Medicaid funding in 2009 alone. *See* Kaiser Found., *Medicaid Spending, FY2009*. If the threatened loss of 100% of federal Medicaid funding—literally billions of dollars and nearly half of all federal funding—is not sufficient to pass the "point at which pressure turns into compulsion," *Steward Machine*, 301 U.S. at 591, then the coercion doctrine itself is "more rhetoric than fact," *Dole*, 483 U.S. at 211.

III. Holding The ACA Unconstitutionally Coercive Will Not Lead To Wholesale Invalidation of Spending Legislation.

Whatever difficulties may lie in "fix[ing] the outermost line" at which "inducement or persuasion … go[es] beyond the bounds of power," *Steward Machine*, 301 U.S. at 591, this case does not require the Court to do so. Indeed, the risk is the opposite.

This case combines hallmarks of coercion—including Congress' expressed understanding that States have no alternative but to comply, the massive size of Medicaid, and Congress' decision to condition the entire funding stream on acceptance of the new conditions—that are unlikely to be replicated any time soon. The Medicaid expansion's mandatory nature and its uniqueness are both confirmed by its close relationship with the individual mandate, which all recognize is quite literally unprecedented. But while striking down the ACA's Medicaid expansion would endanger no other laws, upholding it would signal definitively that, when it comes to using established federal spending programs as leverage over the machinery of state governments, only Congress is guarding the henhouse. The sole guarantee of the fundamental division of authority between the States and the federal government, and the sole protection for the individual liberty that the division secures, would be Congress' "underdeveloped capacity for self-restraint." *Garcia*, 469 U.S. at 588 (O'Connor, J., dissenting).

The invalidation of the ACA and its illusory choice on Medicaid would not call into question the vast bulk of spending legislation because the ACA is unique in several material respects.[18] First, the individual mandate, which all concede is unprecedented, clearly informs the question whether the ACA's Medicaid provisions are voluntary. Federal statutes generally seek to achieve some objective, but do not purport to achieve near-universal compliance. In that normal context, if a State opts out and a federal objective is not fully achieved in a particular State, the federal program is not endangered and the State's opt out is an acceptable cost of our federal system. The individual mandate is different. By requiring nearly every individual to obtain a qualifying health insurance policy, the ACA cannot tolerate a State opting out. The consequence of an opt out—that individuals under a federal mandate to obtain insurance will have no means of doing so—is not one the ACA can abide. But that problem is unique to the ACA. It is the combination of the mandate and the absence of any alternative means of supply for the most needy that creates the irrefutable evidence that the choice is illusory when it comes to Medicaid. Since the individual mandate is unprecedented, so too is the coercion problem.

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[18] It would, however, necessitate invalidation of the entire ACA. For the reasons detailed in the Brief of State Petitioners on Severability, the Medicaid expansion is a critical component of Congress' supply-meets-demand scheme for "near-universal" health insurance coverage. ACA § 1501(a)(1)(D). Through the combined effects of the Medicaid expansion and the individual mandate, Congress envisioned an additional 16 million

The lack of meaningful choice is then underscored by other provisions of the Act that evince Congress' understanding that the Medicaid

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individuals—fully half of the 32 million individuals Congress expected to obtain insurance as a result of the Act—enrolling in Medicaid. CBO Estimate 9 (Mar. 20, 2010). Because the ACA could not function "in a *manner* consistent with the intent of Congress" absent the massive Medicaid expansion, *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987), Title II cannot be severed from the balance of the ACA.

expansion is not voluntary. As noted, the Act provides federal alternatives when States are given meaningful choices whether to accept federal funds and makes arrangements for individuals not eligible for Medicaid to take advantage of federal subsidies. By providing no such alternative arrangements for achieving Congress' goal of near-universal insurance coverage in States that opt out of Medicaid, the Act confirms its coercive nature in a way that is unlikely to be replicated elsewhere.

Equally important, there simply are no federal spending programs of the same magnitude as Medicaid. Indeed, there are very few programs that could be characterized as coming anywhere close. According to the Census Bureau's report on federal aid to States in 2009, nearly half of spending programs disbursed less than $10 million in aid to all 50 States *combined*. *See* U.S. Census Bureau, Dep't. of Commerce, *Federal Aid to States for Fiscal Year 2009*, App. A & Table 1 (2010).[19] For about 200 programs, that number was less than $1 million. And as to some programs—even some of the larger programs—any coercion claim would be readily refuted by the fact that States not only can but often *do* turn down federal funds.

Even the largest federal spending programs are significantly smaller than Medicaid. Only about 5% of all federal programs distributed $1 billion *nationwide* in 2009, whereas Medicaid distributed more than that to most of the individual States. The second largest spending program (the Federal Aid Highways Program, at $35.6 billion nationwide) was less than one seventh the size of Medicaid ($256 billion) and disbursed $200 billion less. Other major initiatives such as Temporary Assistance for Needy Families and the Child Nutrition Program were less than one tenth the size of Medicaid. Combined spending on *all* of the different programs administered by the Department of Education—traditionally one of the largest sources of federal funding to States—was about $45 billion, less than a fifth of the amount disbursed under Medicaid.

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[19] Available at http://www.census.gov/prod/2010pubs/fas-09.pdf.

Those figures are not meant to suggest that coercion concerns will never arise outside the context of Medicaid or its fiscal equivalent. But they do illustrate that the number of programs with the potential to raise coercion concerns of this magnitude is relatively small. Moreover, even as to the few programs large enough to present the opportunity for Congress to attempt to coerce the States, most coercion concerns still would arise only when Congress seeks to impose conditions on *entire blocks* of federal funding. Congress has many means of employing its spending power to achieve its policy objectives without resorting to that most drastic of measures. *See supra*, pp. 4–6.

To the extent that alternative means might be insufficient to achieve uniform compliance among the States, that is a virtue of the coercion doctrine, not a vice. *See Lopez*, 514 U.S. at 581 (Kennedy, J., concurring) (federalism ensures that "States may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear"). When a spending program becomes so massive that Congress and courts alike recognize that "a complete withdrawal of the federal prop in the system ... could seriously cripple a state's" ability to function, *Harris*, 448 U.S. at 309 n.12, the Constitution should demand careful scrutiny of spending legislation that is deliberately crafted to exploit that reliance.

Indeed, the Fourth Circuit has recognized as much for years without invalidating any spending legislation or being bombarded with coercion claims. *See Madison*, 474 F.3d at 128 ("[A] Spending Clause statute that conditions an entire block of federal funds on a State's compliance with a federal directive raises coercion concerns."). As the Fourth Circuit's experience reflects, in the vast majority of instances, Congress does exercise its spending power constitutionally, and States do enter into (or decline to enter into) conditional spending programs "voluntarily and knowingly." *Pennhurst*, 451 U.S. at 17. All of that is but to say that recognizing a constitutional constraint on Congress' spending power under the unique circumstances here—where Congress expressly recognized that States had no choice but to comply and ensured as much by putting the entirety of Medicaid at risk—will prevent the worst abuses while preserving Congress' legitimate ability to "fix the terms on which it shall disburse federal money to the States." *New York*, 505 U.S. at 158.

By contrast, judicial approval of this unprecedentedly coercive legislation would signal the end to any meaningful judicial effort to curb Congress' exercise of the spending power. Whether the Court does so implicitly by upholding the legislation or explicitly by embracing the federal government's position that "Congress *should* be able to place any and all conditions it wants on the money it gives to the states," Pet. App. 59a–60a, the consequences would be dire indeed. The federal balance on which our Constitution is premised could be circumvented by invocation of the spending power. Anything that Congress cannot achieve directly could be achieved indirectly through conditions on federal funds. Nothing would stop Congress from using its spending power to double or triple States' Medicaid obligations in the next bill, or from forcing States to impose an individual mandate to qualify for Medicaid funds.

Ultimately, the problem with the federal government's position is less the parade of horribles than the structural damage to our constitutional system. The scope of the federal government's power is much debated, but the fact that its powers are limited and enumerated is common ground to all. A judicial doctrine that implicitly or explicitly allows Congress to use the spending power without meaningful judicial supervision is simply not compatible with that basic premise of our system. Even when ascertaining judicially manageable lines is difficult, this Court has refused simply to "admit inability to intervene" when an exercise of Congress' power has "tipped the scales" of power too far in the federal government's favor. *Lopez*, 514 U.S. at 578 (Kennedy, J., concurring). If the Court declines to intervene even in a case like this, where Congress' coercion was open and notorious, it welcomes more of the same and risks tipping the scales of power irretrievably against the sovereign States.

CONCLUSION

For the foregoing reasons, the Court should hold the ACA's Medicaid expansion unconstitutional and therefore hold the ACA invalid in its entirety.

Respectfully submitted,

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508

BILL COBB
Deputy Attorney General for
Civil Litigation
Office of the Attorney
General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

January 10, 2012 *Counsel for Petitioners*

Statutory Appendix

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U.S. Const., art. I § 8, cl. 1,

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States[.]

U.S. Const., amend. X

The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

RELEVANT PROVISIONS OF THE PATIENT PROTECTION & AFFORDABLE CARE ACT, PUB. L. NO. 111-148, AS AMENDED BY THE HEALTH CARE & EDUCATION RECONCILIATION ACT OF 2010, PUB. L. NO. 111-152

SEC. 1501. [42 U.S.C. 18091]. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) FINDINGS.—Congress makes the following findings:

(1) IN GENERAL.—The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic

cost. (F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South- Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

"Sec. 5000A. Requirement to maintain minimum essential coverage.

"SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

"(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.— An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

"(b) SHARED RESPONSIBILITY PAYMENT.—

"(1) IN GENERAL.— If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

"(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

"(3) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

"(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

"(c) AMOUNT OF PENALTY.—

"(1) IN GENERAL.— The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

"(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

"(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

"(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1⁄12 of the greater of the following amounts:

"(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

"(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

"(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

"(B) PERCENTAGE OF INCOME.—As revised by section 1002(a)(1) of HCERA An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

"(i) 1.0 percent for taxable years beginning in 2014.

"(ii) 2.0 percent for taxable years beginning in 2015.

"(iii) 2.5 percent for taxable years beginning after 2015.

"(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

"(B) PHASE IN.—The applicable dollar amount is $95 for 2014 and $350 for 2015.

"(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.— If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

"(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

"(i) $695, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2015' for 'calendar year 1992' in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

"(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

"(i) the modified *adjusted* gross income of the taxpayer, plus "(ii) the aggregate modified *adjusted* gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(C) MODIFIED ADJUSTED GROSS INCOME.— The term 'modified gross income' means gross income—

"(i) any amount excluded from gross income under section 911, and

"(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

"(2) RELIGIOUS EXEMPTIONS.—

"(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

"(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1) and "(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

"(B) HEALTH CARE SHARING MINISTRY.—

"(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

"(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

"(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

"(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

"(III) members of which retain membership even after they develop a medical condition,

"(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

"(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

"(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

"(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

"(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

"(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

"(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

"(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

"(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

"(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

"(2) TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

"(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

"(4) MONTHS DURING SHORT COVERAGE GAPS.—

"(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

"(B) SPECIAL RULES.—For purposes of applying this paragraph—

"(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

"(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

"(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

"(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

"(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

"(1) IN GENERAL.—The term 'minimum essential coverage' means any of the following:

"(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

"(i) the Medicare program under part A of title XVIII of the Social Security Act,

"(ii) the Medicaid program under title XIX of the Social Security Act,

"(iii) the CHIP program under title XXI of the Social Security Act,

"(iv) the TRICARE for Life program,

"(v) the veteran's health care program under chapter 17 of title 38, United States Code, or

"(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers).

"(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

"(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

"(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

"(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the

Secretary, recognizes for purposes of this subsection.

"(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

"(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

"(B) any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

"(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' shall not include health insurance coverage which consists of coverage of excepted benefits—

"(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

"(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

"(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

"(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

"(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

"(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

"(g) ADMINISTRATION AND PROCEDURE.—

"(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

"(2) SPECIAL RULES.—Notwithstanding any other provision of law—

"(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

"(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

"(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

"(ii) levy on any such property with respect to such failure.".

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

"CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking "or" at the end of subclause (VI);

(B) by adding "or" at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

"(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);".

(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

(A) IN GENERAL.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

"(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section.".

(B) CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—

(i) in paragraph (24), by striking "or" at the end;

(ii) in paragraph (25), by striking the period and inserting "; or"; and

(iii) by adding at the end the following:

"(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).".

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting "subsection (y) and" before "section 1933(d)"; and

(B) by adding at the end the following new subsection:

"(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

"(1) AMOUNT OF INCREASE.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to—

"(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

"(B) 95 percent for calendar quarters in 2017;

"(C) 94 percent for calendar quarters in 2018;

"(D) 93 percent for calendar quarters in 2019; and

"(E) 90 percent for calendar quarters in 2020 and each year thereafter.

"(2) DEFINITIONS.—In this subsection:

"(A) NEWLY ELIGIBLE.—The term 'newly eligible' means, with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

"(B) FULL BENEFITS.—The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).".

(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—

(A) IN GENERAL.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

"(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2011, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(B) PRESUMPTIVE ELIGIBILITY.—Section 1920 of the Social Security Act (42 U.S.C. 1396r–1) is amended by adding at the end the following:

"(e) If the State has elected the option to provide a presumptive eligibility period under this section or section 1920A, the State may elect to provide a presumptive eligibility period (as defined in subsection (b)(1)) for individuals who are eligible for medical assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall establish.".

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking "and (XIV)" and inserting "(XIV)" and by inserting "and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)" before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking "100" and inserting "133".

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xii);

(ii) by inserting "or" at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

"(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),".

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(i)(VIII)," after "1902(a)(10)(A)(i)(VII),".

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u– 7(a)(1)(B)) is amended by inserting "subclause (VIII) of section 1902(a)(10)(A)(i) or under" after "eligible under".

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking "and" at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting "; and"; and

(C) by inserting after paragraph (73) the following new paragraph:

"(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg)."; and

(2) by adding at the end the following new subsection:

"(gg) MAINTENANCE OF EFFORT.—

"(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE

EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

"(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

"(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on

December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

"(4) DETERMINATION OF COMPLIANCE.—

"(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.— A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO

COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).".

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each";

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)" after "subsection (a)(1),";

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses

(vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services."; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

"(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph

(1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

"(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).".

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking "and" at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting "; and"; and

(C) by inserting after paragraph (74) the following new paragraph:

"(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

"(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

"(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

"(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.".

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national

and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.— Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking "or" at the end;

(ii) in subclause (XIX), by adding "or" at the end; and

(iii) by adding at the end the following new subclause:

"(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);" and

(B) by adding at the end the following new subsection:

"(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

"(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931.".

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xiii);

(ii) by inserting "or" at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

"(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),".

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "1902(a)(10)(A)(ii)(XX)," after "1902(a)(10)(A)(ii)(XIX),".

(C) Section 1920(e) of such Act (42 U.S.C. 1396r–1(e)), as added by subsection (a)(4)(B), is amended by inserting "or clause (ii)(XX)" after "clause (i)(VIII)".

SEC. 2002. INCOME ELIGIBILITY FOR NONELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

"(14) INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—

"(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

"(B) NO INCOME OR EXPENSE DISREGARDS.—Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

"(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

"(D) EXCEPTIONS.—

"(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR

MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

"(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

"(II) Individuals who have attained age 65.

"(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

"(IV) Individuals described in subsection (a)(10)(C).

"(V) Individuals described in any clause of subsection (a)(10)(E).

"(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

"(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

"(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

"(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

"(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

"(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

"(G) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms 'modified gross income' and 'household income' have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

"(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

> "(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or
>
> "(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.

"(I) TREATMENT OF PORTION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

"(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and

"(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.".

(b) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting "(e)(14)," before "(l)(3)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2014.

SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting "or the care and services themselves, or both" before "(if provided in or after".

RESPONDENT'S BRIEF

No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF FOR RESPONDENTS
(Medicaid)

DONALD B. VERRILLI, JR.
Solicitor General
Counsel of Record

TONY WEST
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

BETH S. BRINKMANN
Deputy Assistant Attorney General

LEONDRA R. KRUGER
Assistant to the Solicitor General

MARK B. STERN
ALISA B. KLEIN
Attorneys

Department of Justice
Washington, D.C. 20530-0001
SupremeCtBriefs@usdoj.gov
(202) 514-2217

GEORGE W. MADISON
General Counsel
Department of the Treasury
Washington, D.C. 20220

M. PATRICIA SMITH
Solicitor of Labor
Department of Labor
Washington, D.C. 20210

WILLIAM B. SCHULTZ
Acting General Counsel

KENNETH Y. CHOE
Deputy General Counsel
Department of Health and Human Services
Washington, D.C. 20201

QUESTION PRESENTED

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, provides that, beginning in 2014, eligibility for Medicaid shall extend to certain individuals with income up to 133% of the federal poverty level. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2010).

The question presented is whether the extension of Medicaid eligibility is a valid exercise of Congress's power to set the terms on which it will appropriate federal funds.

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In the Supreme Court of the United States

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v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

ON WRIT OF CERTIORARI
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FOR THE ELEVENTH CIRCUIT

BRIEF FOR RESPONDENTS
(Medicaid)

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-273a[1]) is reported at 648 F.3d 1235. The district court's opinion on the federal government's motion to dismiss (Pet. App. 394a-475a) is reported at 716 F. Supp. 2d 1120. The district court's opinion on the parties' cross-motions for summary judgment (Pet. App. 274a-368a) is reported at 780 F. Supp. 2d 1256.

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2011. The petition for a writ of certiorari was filed on September 27, 2011, and was granted on November 14, 2011. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

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[1] All citations are to the appendix to the federal government's certiorari petition in No. 11-398.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Pertinent constitutional and statutory provisions are set forth in the appendix to this brief. App., *infra*, 1a-26a.

STATEMENT

A. Statutory Background

1. The Medicaid Act, enacted in 1965 in Title XIX of the Social Security Act (SSA), 42 U.S.C. 1396 *et seq.*,[2] establishes a cooperative federal-state program to fund medical care for needy individuals. Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 121(a), 79 Stat. 343; see *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 275 (2006). "States are not required to participate in Medicaid, but all of them do." *Ibid.*

"The Federal Government shares the costs of Medicaid with States that elect to participate in the program. In return, participating States are to comply with requirements imposed by the Act and by the Secretary of Health and Human Services." *Atkins* v. *Rivera*, 477 U.S. 154, 156-157 (1986). "Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of the [Medicaid Act]." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see also *Frew* v. *Hawkins*, 540 U.S. 431, 433 (2004) ("State participation is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements.").

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[2] Unless otherwise indicated, all citations to the United States Code refer to the 2006 edition and Supplement IV (2010).

To be eligible for federal funds, a State that elects to participate in the Medicaid program must submit a plan to the Secretary of Health and Human Services (HHS) that meets the Medicaid Act's requirements. 42 U.S.C. 1396a. If the Secretary approves a state plan (or plan amendment), the federal government reimburses the State for a percentage of qualified Medicaid expenses. The federal contribution rate generally falls between 50% and 83%, depending on a State's per capita income. 42 U.S.C. 1396d(b).

Since Medicaid's enactment in 1965, the basic terms of the program have required participating States to fund the provision of certain health care benefits to specific categories of needy individuals. See 42 U.S.C. 1396a(a)(10); *Pharmaceutical Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 650-651 & n.4 (2003). Participating States must also comply with various administrative requirements, including requirements that protect the Medicaid program from waste, fraud, and abuse, *e.g.*, 42 U.S.C. 1396a(a)(69); protect the health and safety of Medicaid beneficiaries, *e.g.*, 42 U.S.C. 1396a(a)(9); protect the privacy of beneficiary information, 42 U.S.C. 1396a(a)(7); and ensure that payments for care and services are sufficient to accomplish the goals of the program, 42 U.S.C. 1396a(a)(30)(A) (the provision at issue in *Douglas* v. *Independent Living Center*, No. 09-958, and consolidated cases (argued Oct. 3, 2011)). In addition, state Medicaid programs must comply with federal civil rights statutes applicable to programs that receive funding from HHS. See, *e.g.*, 45 C.F.R. Pt. 80 (implementing Title VI of the Civil Rights Act of 1964); 45

C.F.R. Pt. 84 (implementing Section 504 of the Rehabilitation Act of 1973).

Beyond those minimum requirements, States may choose to cover additional categories of enrollees and to provide additional medical benefits, generally at the same rate of federal reimbursement. See, *e.g.*, 42 U.S.C. 1396a(a)(10)(A)(ii) and (C). Every State has elected to extend eligibility to some optional populations and to cover some optional benefits. See Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options*, App. B, Tbl. 1, at 4 (Jan. 2012) (*Medicaid Enrollment and Expenditures*). By 2007, the cost of the coverage States chose to provide to optional beneficiaries and for optional benefits had grown to account for approximately 60% of all Medicaid spending. *Id.* at 1.

The Secretary enforces state compliance with federal Medicaid requirements. The Medicaid Act provides that if, after giving a State notice and an opportunity for a hearing, the Secretary finds that the State is failing to comply substantially with a provision of the Medicaid Act, the Secretary shall notify the State "that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply." 42 U.S.C. 1396c. Under the implementing regulations, before holding a hearing, the Secretary generally must first make reasonable efforts to resolve an issue of compliance with a State. 42 C.F.R. 430.35, 430.70.

2. In the Social Security Act, 42 U.S.C. 301 *et seq.*, of which the Medicaid Act is a part, Congress expressly reserved the "right to alter, amend, or repeal any provi-

sion" of the Act. 42 U.S.C. 1304; see *Bowen* v. *Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 44 (1986). Each State Medicaid plan expressly provides that its plan "will be amended whenever necessary to reflect * * * [c]hanges in Federal law." 42 C.F.R. 430.12(c)(1)(i) (requiring all States participating in Medicaid to include such provisions in their plans); see, *e.g.*, Florida Agency for Health Care Admin., *State Plan Under Title XIX of the Social Security Act Medical Assistance Program* § 7.1, at 86 (Oct. 6, 1992). Consistent with the Act's express reservation of authority, Congress has amended the Medicaid Act many times since 1965, and has frequently expanded the scope of mandatory eligibility as well as the definition of mandatory benefits.

When Medicaid was first established in 1965, the program required participating States to provide medical assistance to individuals receiving welfare benefits under one of four federal programs administered by the States: Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind, or Aid to the Permanently and Totally Disabled. See 42 U.S.C. 1396a(a)(10) (1970); *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 37 (1981). In 1972, Congress replaced the latter three programs with Supplemental Security Income for the Aged, Blind, and Disabled (SSI). *Id.* at 38 (citing Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1465). Under the SSI program, Congress "displaced the States by assuming responsibility for both funding payments and setting standards of need." *Ibid.* The effect in some States was to extend Medicaid eligibility, according to federal standards of need, to individuals who had not previously been eligible under standards set under state-run programs. *Ibid.* Congress provided, however, that States could elect to limit the expansion of Medicaid as long as they maintained eligibility for individuals who would have been eligible under the state Medicaid plan in effect on January 1, 1972 (the "209(b) option"), based on standards set under state-run welfare programs. States that elected the 209(b) option were required not only to maintain then-current levels of Medicaid eligibility, but also "to adopt a 'spend-down' provision" under which "an individual otherwise eligible for SSI but whose income exceeded the state standard could become eligible for Medicaid when that part of his income in excess of the standard was consumed by expenses for medical care." *Id.* at 38-39 & nn.4 & 5. A minority of States exercised that option. *Id.* at 39 n.6. Thus, under either the SSI expansion or the 209(b) option, States choosing to participate in Medicaid were obligated to provide coverage to substantial numbers of individuals not included within the scope of mandatory coverage before the 1972 amendment.

Beginning in the 1980s, Congress expanded Medicaid eligibility beyond individuals receiving cash welfare assistance. See generally John D. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Fin. Rev. 105, 108 (Fall 2000). "The expansions affected nearly the entire spectrum of Medicaid enrollees from infants, children, and pregnant women to low-income Medicare beneficiaries, and other aged and disabled enrollees." *Ibid.* States were initially given the discretion to offer coverage to these groups, but subsequent legislation made the expanded eligibility mandatory for States that chose to participate in Medicaid. *Ibid.*; see, *e.g.*, Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2258 (extending eligibility to pregnant women and children under age six, with household income up to 133% of the federal poverty level); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4601, 104 Stat. 1388-166 (extending eligibility to children aged 6 through 18 with household income up to 100% of the federal poverty level). At each step in the process of expanding eligibility, every State elected to continue participating. As of 2008, Medicaid provided coverage to approximately 47 million Americans. Centers for Medicare & Medicaid Servs., HHS, *2010 Actuarial Report on the Financial Outlook for Medicaid* Tbl. 3, at 19 (Dec. 21, 2010) (*2010 Actuarial Report*).

Despite these expansions, many low-income individuals have remained ineligible for Medicaid (and unable to afford health care on their own). Adults under age 65 who are not caring for dependent children and who are not pregnant or disabled have generally been ineligible for Medicaid, no matter their income. See 42 U.S.C. 1396d(a) (listing categories of persons eligible for medical assistance).[3] For parents caring for dependent children, eligibility standards have varied by State, but as of January 2012, the median eligibility cap was 37% of the federal poverty level for unemployed parents and 63% of the federal poverty level for parents who have earnings. Kaiser Comm'n on Medicaid and the Uninsured, *Performing Under Pressure: Annual Findings*

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[3] Some States have received authorization to carry out renewable "demonstration projects" under which they have extended coverage to these adults. See 42 U.S.C. 1315 (authorizing the Secretary to waive certain requirements for state plans under the Medicaid Act to allow States to carry out certain demonstration projects); CMS, *Medicaid and CHIP Program Information: Waivers*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (providing information about state demonstration projects).

of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP 2011-2012, at 11 & Fig. 11 (Jan. 2012). And, even though States, at their option, could receive federal Medicaid funds to cover parents at higher income levels, 17 States have limited Medicaid eligibility for working parents to parents with incomes below 50% of the federal poverty level. *Ibid.*

3. Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act or Act),[4] to address a crisis in the national health care market that exists because tens of millions of Americans cannot afford health insurance and thus cannot reliably obtain adequate health care.

One of the principal means by which Congress addressed the crisis was by extending Medicaid eligibility to certain individuals under 65, not receiving Medicare, and with incomes up to 133% of the federal poverty level. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII).[5] The persons

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[4] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[5] Except in Alaska and Hawaii, the federal poverty level in 2010 was $10,830 for one person and $22,050 for a family of four. 75 Fed. Reg. 45,629 (Aug. 3, 2010).

Petitioners' reference to 138% (rather than 133%) of the federal poverty level, States' Br. 7, reflects Congress's adjustments to the use of "income disregards" in determining Medicaid eligibility. Historically, States used income disregards to exclude certain amounts of income when evaluating an applicant's eligibility for medical assistance. Those disregards varied from State to State, and had the effect of raising the eligibility ceiling for such programs. To achieve consistency, Congress in the Affordable Care Act generally eliminated the use of disregards other than a standard 5% income disregard and prescribed a new modified adjusted gross income standard to be used in determining eligibility. 42 U.S.C. 1396a(e)(1)(A), (B), (D) and (I). See generally made newly eligible for Medicaid are primarily low-income adults under age 65 who are not disabled and do not have children. See Congressional Budget Office, *CBO's 2011 Long-Term Budget Outlook* 38 (June 2011) (*Budget Outlook*).

The Affordable Care Act does not require States to provide the traditional Medicaid benefit package to individuals covered by the eligibility expansion, instead applying the Medicaid Act's "benchmark" or "benchmark-equivalent" coverage provisions. 42 U.S.C. 1396a(k)(1); see 42 U.S.C. 1396u-7(b). Under those provisions, States must provide coverage that includes defined health benefits and meets certain other requirements, but may choose options that may be less comprehensive than the traditional Medicaid benefit package. *Ibid.*

The federal government will bear nearly the entire cost of medical assistance for individuals made newly eligible by the Affordable Care Act. From 2014 through 2016, the federal government will pay 100% of the costs of providing medical assistance associated with the extension of eligibility. 42 U.S.C. 1396d(y). That amount will gradually decrease, to 95% in 2017, 94% in 2018, and 93% in 2019. *Ibid.* In 2020 and thereafter, the federal government will pay 90% of these costs. *Ibid.* That level of support significantly exceeds the typical federal contribution rates, which range from 50% to 83% of a State's Medicaid expenditures and which have generally averaged 57%. See 42 U.S.C. 1396d(b); *2010 Actuarial Report* 20.

Kaiser Comm'n on Medicaid & the Uninsured, *Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP* (May 2008).

Moreover, although the federal government ordinarily pays 50% of most state administrative costs, 42 U.S.C. 1396b(a)(2)-(5) and (7), through 2015 the federal government will pay 90% of state administrative expenses incurred to upgrade state information systems for making eligibility determinations. See 76 Fed. Reg. 21,950 (Apr. 19, 2011).

The Congressional Budget Office (CBO) has projected that state Medicaid spending will increase by $20 billion between 2010 and 2019 as a result of the Affordable Care Act, as compared to an increase in federal Medicaid spending of $434 billion over the same period. Letter from Douglas Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, United States House of Representatives Tbl. 4 & n.c (Mar. 20, 2010) (CBO Letter); see States' Br. 10. The projected increase is approximately 0.8% above what States were projected to have spent on Medicaid without the Affordable Care Act. See CBO, *Spending & Enrollment Detail for CBO's March 2009 Baseline: Medicaid* (*2009 Baseline Spending and Enrollment Detail*).[6]

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[6] Without the Affordable Care Act, federal Medicaid payments between 2010 and 2019 were projected to total approximately $3.3 trillion and to constitute 57% of total Medicaid spending. *2009 Baseline Spending and Enrollment Detail*. State Medicaid spending in the absence of the Affordable Care Act was projected to account for the remaining 43%, *ibid.*, or $2.47 trillion.

Petitioners cite (States' Br. 10) another study estimating that increased state spending will range from $21.1 billion to $43.2 billion, depending on the rate of increased enrollment. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* 19-20, 23 (May 2010). Even at the high end of that range, the projected increase would represent an increase of approximately

That 0.8% increase in state Medicaid spending will likely be more than offset by other savings States will achieve as a result of the Affordable Care Act's reforms. The Act will reduce state costs by, for example: shifting certain adults from optional Medicaid coverage to health insurance bought through the health insurance exchanges (with the assistance of federal premium tax credits and cost-sharing reductions), or to Medicaid coverage at a more advantageous federal matching rate; and shifting coverage of mental-health benefits from wholly state-funded programs to Medicaid. See Matthew Buettgens, Stan Dorn & Caitlin Carroll, *Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less With the ACA than Without It from 2014 to 2019*, at 1-10 (July 2011) (*Consider Savings*). In addition, the Act will alleviate the burden on States to pay for the uncompensated care that millions of currently uninsured individuals consume each year. See *id.* at 10; Gov't Minimum Coverage Br. 7-8, 33-37. As a result of these and other effects, studies project that, under the Affordable Care Act, overall state spending will be approximately $100 billion lower through 2019 than it would have been without the changes made by the Act.[7]

1.75% over what States were projected to have spent on Medicaid without the Affordable Care Act.

[7] *Consider Savings* at 4-5 (projected state savings of $92 to $129 billion between 2014 and 2019); The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers* 32 (June 2010) (projected state and local government savings of approximately $107 billion between 2010-2019); see also Stan Dorn & Matthew Buettgens, *Net Effects of the Affordable Care Act on State Budgets*, Tbl. 1, at 2 (Dec.

4. In a separate title of the Affordable Care Act, Congress provided that, beginning in 2014, non-exempted individuals who fail to maintain a minimum level of health insurance coverage for themselves or their dependents will owe a tax penalty for each month in the tax year during which that minimum coverage is not maintained. 26 U.S.C. 5000A(a) and (b). As a result of the Act's design, individuals who would otherwise be eligible for Medicaid would not face a tax penalty for failure to purchase health insurance in the event that a State elects to opt out of Medicaid. Low-income individuals who are not required to file federal income tax returns for a given year are not subject to the tax penalty that is the only consequence of failing to maintain minimum coverage.[8] Congress also exempted, *inter alia*, individuals whose premium payments would exceed 8% of their household income and individuals who establish that obtaining coverage would be a hardship under standards to be set by the Secretary of HHS. 26 U.S.C. 5000A(e). In addition, Congress provided that, beginning in 2014, applicable taxpayers can receive federal premium tax credits to help them purchase insurance through a health insurance exchange. 26 U.S.C. 36B(a).[9]

2010) (concluding that States can realize savings of $40.6 to $131.9 billion between 2014 and 2019).

[8] Generally, for 2011, the threshold for filing income tax returns is $9500 in gross income for a single taxpayer under the age of 65; $12,200 for a head of household under 65; and $19,000 for a married couple under 65 filing jointly. See IRS, *Publication 501: Exemptions, Standard Deduction, and Filing Information* 2-3 & Tbl. 1 (2011), http://www.irs.gov/pub/irs-pdf/p501.pdf.

[9] See 26 U.S.C. 36B(c)(1)(A) (defining "applicable taxpayer" as a taxpayer with household income between 100% and 400% of the federal poverty level), (c)(1)(B) (special rule authorizing federal premium tax

B. Proceedings Below

Petitioners are 24 States, a state attorney general, and a governor. They filed suit in the Northern District of Florida, alleging, as relevant here, that the Affordable Care Act's extension of Medicaid eligibility is not a valid exercise of Congress's power to set the terms on which it will appropriate federal funds. Petitioners argued that the Medicaid program is "coercive" because it would be too disadvantageous for them to withdraw, given the amount of money the federal government provides to fund the provision of health care to their low-income citizens.

Rejecting that argument, the district court explained that "state participation in the Medicaid program under the [Affordable Care] Act is—as it always has been—voluntary." Pet. App. 283a. The district court further explained that petitioners failed to offer a "judicially manageable standard or coherent theory" for deeming a federal spending program to be "coercion," and that "every single federal Court of Appeals called upon to consider the issue has rejected the coercion theory as a viable claim." *Id.* at 285a (citing cases).

The court of appeals affirmed in relevant part. Pet. App. 50a-63a. The court reasoned that this Court's decision in *South Dakota* v. *Dole*, 483 U.S. 203 (1987),

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credits for qualified aliens lawfully present in the United States with income less than 100% of the federal poverty level who are not eligible for Medicaid because of their alien status), (c)(2)(B)(i) (providing exception for any coverage month in which "the individual is eligible for minimum essential coverage other than eligibility for coverage described in [26 U.S.C. 5000A(f)(1)(C)] (relating to coverage in the individual market)," which includes months during which an individual is eligible for Medicaid because, *inter alia*, her income is less than 133% of the federal poverty level).

"instructs * * * that Congress cannot place restrictions so burdensome and threaten the loss of funds so great and important to the state's integral function as a state—funds that the state has come to rely on heavily as part of its everyday service to its citizens—as to compel the state to participate in the 'optional' legislation." Pet. App. 60a. The court opined that "[t]his is the point where 'pressure turns into compulsion.'" *Ibid.* (quoting *Dole*, 483 U.S. at 211, and *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 590 (1937)). Observing that "no court has ever struck down a law such as this one as unduly coercive," *id.* at 58a, the court concluded that several factors demonstrate that "the Act's expansion of Medicaid is not unduly coercive under *Dole* and *Steward Machine*," *id.* at 60a. The court explained that Congress expressly reserved the right to alter the Medicaid program, see 42 U.S.C. 1304, and that, since the program's inception, Congress has enacted several mandatory extensions of Medicaid eligibility. Pet. App. 60a-61a. The court also noted that the federal government will bear nearly all of the costs associated with the Affordable Care Act's expansion of Medicaid eligibility; that the Affordable Care Act gave States ample notice—nearly four years from when the legislation was enacted—to determine whether to continue to participate in the Medicaid program; and that States are free to establish their own programs if they do not want to accept the terms offered under the federal program. *Id.* at 61a-62a. And finally, the court explained that the Medicaid Act gives HHS discretion to withhold part or all of Medicaid funding from a State that does not comply with the Act's requirements. *Ibid.* (citing 42 U.S.C. 1396c). In light of those considerations, the court concluded that "the Medicaid-participating states have a real choice—not just in theory but in fact—to participate in the Act's Medicaid expansion." *Id.* at 63a.

SUMMARY OF ARGUMENT

The Affordable Care Act's expansion of the Medicaid program is a constitutional exercise of Congress's Article I authority. Petitioners' challenge to the Act's Medicaid expansion lacks any support in this Court's precedents, invites standardless decisionmaking and intractable problems of administration, and is wrong as a matter of constitutional principle.

1. It is well settled that Congress's spending power includes the power to fix the terms on which it will disburse funds to the States. That power is subject to several general restrictions identified in *South Dakota* v. *Dole*, 483 U.S. 203 (1987), including the obligations to spend funds in pursuit of the general welfare, U.S. Const. Art. I, § 8, Cl. 1, and to make conditions on spending clear and unambiguous. Apart from those restrictions, Congress has broad authority to attach conditions to federal spending in order to further federal policy objectives.

In the Medicaid Act, 42 U.S.C. 1396 *et seq.*, Congress exercised its spending power to create a federal-state cooperative program under which participating States agree to comply with program terms in exchange for the federal government's contribution of a percentage of the costs the State incurs in funding medical assistance. These terms include requirements concerning the categories of needy persons eligible for assistance and the categories of benefits to which they are entitled.

In the Affordable Care Act, Congress filled gaps in existing Medicaid coverage by extending eligibility to additional low-income individuals. Petitioners do not claim that this amendment of the Medicaid program exceeds any of the general restrictions on Congress's spending power described in *Dole*, and no such claim would be tenable. Congress's specification of the additional category of needy individuals entitled to assistance is an unambiguous, foundational term of the Medicaid program that simply prescribes how federal funds must be spent, and requiring a participating State to comply with that term is a valid condition on the disbursement of federal Medicaid funds.

2. Congress's use of the spending power to extend Medicaid eligibility to a new category of low-income individuals does not violate structural principles of federalism by compelling States to implement a federal program.

a. Petitioners' assertion that the Affordable Care Act worked an unprecedented transformation of the Medicaid program rests on a series of mischaracterizations. From the outset, Congress specifically reserved the right "to alter, amend, or repeal any provision" of the Medicaid Act, 42 U.S.C. 1304, and Congress has many times exercised that reserved authority to extend the Medicaid program to new classes of beneficiaries and new kinds of benefits—and has often required States to accept the expansion as a condition of continued participation in the Medicaid program. In the Affordable Care Act, more than in prior Medicaid expansions, Congress took significant steps to reduce the burdens on the States by initially covering all of the costs of funding medical assistance for individuals made eligible by the expansion, and ultimately providing federal assistance at rates far exceeding usual Medicaid matching rates. The resulting additional cost to the States represents less than a 1% increase over their baseline spending and will be more than offset by cost reductions resulting from the Affordable Care Act. Moreover, the Act preserves States' flexibility to respond to budgetary demands by, *inter alia*, adjusting their spending on certain coverage that is optional, rather than mandatory, under the Medicaid Act.

b. This Court has recognized that, unlike a directive to the States to enact or implement a federal regulatory program, Congress's decision to condition the receipt of federal funds on compliance with federal policy respects principles of federalism by leaving it to States to decide whether federal policy is "sufficiently contrary to local interests" to justify declining federal money. *New York v. United States*, 505 U.S. 144, 168 (1992).

Petitioners do not dispute that they are free, as a matter of law, to turn down federal Medicaid funds if they view program conditions as sufficiently contrary to their interests. They contend, however, that the "sheer size" of federal Medicaid grants means they have no practical ability to turn the money down. On their theory of coercion, the greater the federal government's willingness to contribute funds to defray the costs of covering needy individuals (including costs of optional coverage that States chose to add to their Medicaid programs), the less say Congress has in defining the features of its spending program.

No court has accepted such an argument, and for good reason. However attractive the offer of federal Medicaid funding may be, the decision whether to accept it always belongs to the States, and not the federal government. Petitioners' claim of coercion is nothing more than an argument that the citizens of their States would hold them politically responsible for either the reduction in benefits that would result from opting out of Medicaid or for the increased taxation needed to fund those benefits entirely at the state level. That argument turns notions of political accountability and state sovereignty upside down, for it rests on the assumption that States lack the capacity or the will to accomplish on their own what their citizens desire, and therefore have a right under the Constitution to have courts dictate the terms on which the federal government provides assistance.

The amount of money at stake, moreover, cannot be thought to be the only relevant consideration for States deciding whether to accept conditional federal funding, and different States will weigh the costs and benefits differently. Courts are ill-equipped to second-guess state officials' judgments about matters of budget, revenue, and policy. And critically, there is no logical stopping point to petitioners' argument. It would call into question not only the extension of Medicaid eligibility in the Affordable Care Act, but also every other requirement for participation in the Medicaid program, not to mention an unspecified number of other federal spending programs whose terms grant recipients may find coercively generous.

c. Petitioners suggest that the Court need not articulate any clear and administrable rule of constitutional law to decide this case in their favor on "coercion" grounds because Congress itself premised the Affordable Care Act on the understanding that the States could not leave Medicaid. That argument rests in large part on the erroneous assertion that Congress thought the extension of Medicaid eligibility was needed to enable low-income individuals to avoid the tax penalty for failure to maintain minimum health coverage that they would otherwise face. But the minimum coverage provision expressly exempts individuals unable to afford health coverage from the tax penalty that is the only consequence of the failure to maintain minimum coverage.

Petitioners also argue that the Affordable Care Act's coercive nature is evident from Congress's failure to provide a comprehensive fallback for low-income individuals living in States that opt out of Medicaid, demonstrating that Congress expected States would continue to participate. Such an expectation is hardly proof of coercion. All States have participated in Medicaid for decades, and Congress had no reason to anticipate that would change, particularly given that the federal government has assumed nearly all the costs of the eligibility expansion. But Congress's expectations do not, in any event, bear on the constitutional analysis. States remain free to opt out of Medicaid if they so choose, and Congress can then adjust other statutory programs as appropriate.

d. Because the extension of Medicaid eligibility falls well within the bounds of Congress's power to fix the terms on which it will appropriate federal funds, there is no reason for this Court to consider petitioners' passing contention that the remainder of the Affordable Care Act is inseverable from the eligibility extension provision. Moreover, this case provides no occasion to consider the continued viability of countless provisions of the Act that do not affect petitioners, but do affect numerous individuals not before the Court. And in any event, the extension of Medicaid eligibility is an amendment to the Social Security Act, whose severability clause instructs that invalidation of any application of that statute shall not affect the remainder of the statute or its other applications. 42 U.S.C. 1303. Were the eligibility extension provision found to be unconstitutionally coercive, the appropriate remedy would be to enjoin its mandatory application to objecting States, but otherwise to allow the provision to operate as written; it would not be to nullify the Affordable Care Act in its entirety.

ARGUMENT

THE AFFORDABLE CARE ACT'S EXPANSION OF MEDICAID ELIGIBILITY IS A VALID EXERCISE OF CONGRESS'S POWER TO SET THE TERMS ON WHICH IT WILL APPROPRIATE FEDERAL FUNDS FROM THE TREASURY

A. Congress Has Broad Authority Under The Spending Clause And Appropriations Clause To Establish The Criteria For Payment Of Money From The Treasury To Support A Federally Funded Program

1. The Constitution grants Congress the power to "lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. Const. Art. I, § 8, Cl. 1. The Constitution further provides that once the proceeds of taxes and other revenues are deposited in the Treasury, "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law." U.S. Const. Art. I, § 9, Cl. 7. A central purpose of this Clause "is to assure that public funds will be spent according to the letter of the difficult judgments reached by Congress as to the common good." *OPM* v. *Richmond*, 496 U.S. 414, 428 (1990).

Consistent with these fundamental principles governing the appropriation of funds in the Treasury, it has long been settled that Congress's spending power includes the power to "fix the terms on which it shall disburse federal money to the States." *Pennhurst State*

Sch. & Hosp. v. *Halderman*, 451 U.S. 1, 17 (1981); accord, *e.g.*, *Massachusetts* v. *United States*, 435 U.S. 444, 461 (1978); *King* v. *Smith*, 392 U.S. 309, 333 n.34 (1968); *Oklahoma* v. *United States Civil Serv. Comm'n*, 330 U.S. 127, 143 (1947). As this Court has long recognized, "[f]unds in the Treasury as a result of taxation may be expended only through appropriation," *United States* v. *Butler*, 297 U.S. 1, 65 (1936) (citing Art. I, § 9, Cl. 7), and it is "the duty of all courts to observe the conditions defined by Congress for charging the public treasury." *Federal Crop Ins. Corp.* v. *Merrill*, 332 U.S. 380, 385 (1947); see *OPM* v. *Richmond*, 496 U.S. at 424-425.

This Court has further recognized that "Congress may, in the exercise of its spending power, condition its grant of funds to the States upon their taking certain actions that Congress could not require them to take." *College Sav. Bank* v. *Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 686 (1999). Although Congress may not compel States to implement federal regulatory programs, *New York* v. *United States*, 505 U.S. 144, 166 (1992); *Printz* v. *United States*, 521 U.S. 898, 925 (1997), this Court has made clear that Congress may validly condition a grant of funds on a State's agreement to implement programs consistent with the policy embodied in the Acts of Congress providing for the payment of the relevant funds from the Treasury, *New York*, 505 U.S. at 166-167.

Congress's power to condition the grant of federal funds "is of course not unlimited, but is instead subject to several general restrictions." *South Dakota* v. *Dole*, 483 U.S. 203, 207 (1987) (citation omitted). First, consistent with the text of the Spending Clause, "the exercise of the spending power must be in pursuit of 'the general welfare.'" *Ibid.* Second, conditions under programs for grants to the States must be unambiguous, "enabl[ing] the States to exercise their choice knowingly, cognizant of the consequences of their participation." *Pennhurst*, 451 U.S. at 17. Third, the Court has "suggested (without significant elaboration) that conditions on federal grants might be illegitimate if they are unrelated 'to the federal interest in particular national projects or programs,'" *Dole*, 483 U.S. at 207 (citation omitted). Finally, the Court has "noted that other constitutional provisions may provide an independent bar to the conditional grant of federal funds," *id.* at 208 (citations omitted), such that Congress may "not 'induce' the recipient 'to engage in activities that would themselves be unconstitutional,'" *United States* v. *American Library Ass'n, Inc.*, 539 U.S. 194, 203 (2003) (plurality opinion) (quoting *Dole*, 483 U.S. at 210).

These restrictions ensure that the spending power does not "render academic the Constitution's other grants and limits of federal authority." *New York*, 505 U.S. at 167. Beyond these limitations, however, "Congress has wide latitude to attach conditions to the receipt of federal assistance in order to further its policy objectives." *American Library Ass'n*, 539 U.S. at 203 (plurality opinion).

2. Medicaid is a joint federal-state cooperative program enacted pursuant to Congress's Spending Clause authority. Under the program, "the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons." *Harris* v. *McRae*, 448 U.S. 297, 308 (1980). As this Court has repeatedly recognized, "State participation [in Medicaid] is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements." *Frew* v. *Hawkins*, 540

U.S. 431, 433 (2004); see also *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 275 (2006) (in exchange for federal funds, "the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program"); *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990) ("Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services."); *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 37 (1981) ("State Medicaid plans must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services.").

Since the program began in 1965, the conditions for participation have included agreement by the States to make medical assistance available to specified categories of needy individuals. Since then, Congress many times has required States to cover new categories of individuals, including infants, children, pregnant women, and the disabled. A State's willingness to accept an expanded eligibility requirement has been a condition of continued participation in the Medicaid program itself, and not merely a condition of receiving incremental funding. See pp. 5-7, *supra*.

3. In the Affordable Care Act, Congress addressed existing gaps in Medicaid coverage by extending eligibility to individuals under age 65, not receiving Medicare, and earning less than 133% of the federal poverty level. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII). The result will be to make coverage available to millions of low-income individuals who might otherwise lack access to adequate health care or consume health care services in the form

of uncompensated care. See Gov't Minimum Coverage Br. 7-8.

Petitioners do not claim that the extension of Medicaid eligibility to these low-income individuals exceeds any of the "general restrictions" on Congress's spending power identified in *Dole*, 483 U.S. at 207-208, and no such claim would be tenable. As has been true of prior Medicaid expansions, this extension of Medicaid eligibility promotes the general welfare by increasing access to health care for needy persons. It does so in terms that are unambiguous and that directly advance the overall purpose of the Medicaid program. *Ibid.* Like the Medicaid Act's other specifications about the categories of needy individuals entitled to receive assistance and the categories of services they are entitled to receive, the extension of Medicaid eligibility in the Affordable Care Act is a valid condition on a State's participation in and receipt of federal funds under the Medicaid program.

Indeed, the additional eligibility standards in the Affordable Care Act, like the prior standards, are not mere conditions, designed to further a goal related to the Medicaid program (although, as *Dole*, 483 U.S. at 207, and *New York*, 505 U.S. at 166-167, make clear, Congress may impose such conditions). The eligibility standards *define* the Medicaid program, going to the very core of the offer of federal financial assistance that Congress has extended to the States and specifying how the federal dollars will be spent. For the same reasons, the new eligibility standards in the Affordable Care Act, like pre-existing standards, also go to the very core of Congress's power under the Spending Clause and the Appropriations Clause to specify the criteria under which funds in the Treasury will be paid out and spent. Congress is choosing to act in conjunction with the

States, and prescribing the terms on which federal money will be spent, in an area in which Congress has Article I authority to act directly by establishing and funding a federal program (as it has done, for example, with the Medicare program, see 42 U.S.C. 1395 *et seq.*). In doing so, Congress has acted well within constitutional bounds.[10]

B. The Nature Of the Medicaid Program And The Amount Of The Federal Funding Provided Under It Do Not Extinguish Congress's Authority To Set The Terms On Which It Will Appropriate Money In The Treasury

Petitioners contend (Br. 32-53) that, in enacting the Affordable Care Act, Congress violated structural principles of federalism by "[f]orc[ing]" States to accept Congress's decision to expand Medicaid eligibility. *Id.* at 33. Petitioners do not dispute that, as a matter of federal law, a State remains free to withdraw from the Medicaid program if it does not wish to accept federal funds on the terms under which they are offered. See Pet. App. 283a-284a. But petitioners contend that the "sheer size" of federal Medicaid grants makes it impractical to turn the money down rather than agree to the expanded coverage. States' Br. 23; *id.* at 39-48.

As explained below, petitioners greatly exaggerate the burden on the States resulting from the extension of Medicaid eligibility to additional populations—especially in the context of the Medicaid program as a whole, and the federal government's assumption of the great majority of the incremental costs. And the savings to the States under the Affordable Care Act are expected to more than offset the increase in expenditures from the extension of Medicaid eligibility. Even more to the point, no decision of this Court—nor, indeed, of any other court—supports petitioners' contention that a State's reluctance to turn down federal Medicaid funds entitles it to ignore the Medicaid program's basic eligibility standards, which define the very core of the program, and to insist that money from the Treasury be appropriated to it on the terms the State would prefer rather than the terms Congress has prescribed.

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[10] Even Justice O'Connor's dissenting opinion in *Dole*, which would have held the 21-year-old drinking-age condition on federal highway funds unconstitutional on the ground that it was not sufficiently related to the purpose for which the funds were granted to the States, recognized that Congress has full power to specify how federal funds will be spent. 483 U.S. at 216.

1. *The extension of Medicaid eligibility in the Affordable Care Act is neither unprecedented nor likely to impose significantly onerous burdens on the States*

As an initial matter, it is necessary to put petitioners' objections to the extension of Medicaid eligibility into perspective, for a claim that a federal spending program is coercive, even if viable in theory, must be considered in context. Although petitioners depict the extension of Medicaid eligibility in the Affordable Care Act as a "transformative" development in the history of Medicaid, *e.g.*, States' Br. 7, 40, petitioners acknowledge that the Medicaid Act always has mandated coverage for various categories of individuals and benefits, and that Congress has expanded these mandatory categories over time—requiring States to choose whether to accept the expanded obligations or to withdraw from the Medicaid program. See, *e.g.*, *id.* at 5 ("By the end of the decade [*i.e.*, 1989], Congress mandated coverage for all pregnant women, children age 5 and under with family incomes below 133% of the federal poverty level, and children between the ages of 6 and 18 with family incomes below the federal poverty level.") (citations omitted); *id.* at 5-6 ("Congress periodically increased eligibility thresholds for certain categories of needy.").

In fact, more than in prior Medicaid expansions, Congress took steps in the Affordable Care Act to reduce the burden on the States. The federal government will initially pay 100% of the costs associated with providing medical assistance to individuals covered under the eligibility expansion. 42 U.S.C. 1396d(y). Over the remainder of the decade, that amount will gradually decrease to and then remain indefinitely at 90%—a rate still far greater than the usual federal contribution rates. See 42 U.S.C. 1396d(b) (prescribing federal contribution rates between 50% and 83%); p. 9, *supra* (federal contribution rates have generally averaged 57%).

As petitioners note, CBO has projected that state Medicaid spending will increase by $20 billion between 2010 and 2019 beyond what it would have been over that decade without the Affordable Care Act. But that amount is dwarfed by the projected increase in federal spending of $434 billion. See States' Br. 10 (citing CBO Letter, Tbl. 4 & n.c). Moreover, that amount represents less than a 1% increase over baseline state Medicaid spending (*i.e.*, projected state Medicaid spending without the Affordable Care Act over the same ten-year period). See p. 10, *supra.*[11] The projected increase in the

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[11] As noted above, accepting the upper end of the estimates of increased state spending cited by petitioners (States' Br. 10), that number represents less than a 2% increase over baseline state Medicaid spending. See n.6, *supra*.

Petitioners also cite CBO analyses projecting that Medicaid enrollment will increase by 16 million between 2010 and 2020 as a result of the Affordable Care Act. See States' Br. 9-10 (citing CBO Letter 9).

States' spending is also a mere fraction of current spending for categories of individuals and benefits whose coverage is optional, rather than mandatory, under the Medicaid Act. In 2007 alone, for example, combined federal and state spending on enrollees covered at state option totaled $129 billion, and combined spending on services covered at state option for both mandatory and optional enrollees totaled $103.4 billion. *Medicaid Enrollment and Expenditures* 2.

The projected increase in state spending will, moreover, be offset by reductions in other state costs resulting from implementation of the Affordable Care Act, including, among other things, reductions in state costs for uncompensated care. As pointed out above (see p. 11 & n.7, *supra*), several studies have projected that aggregate state spending over the course of the decade will be approximately $100 billion *lower* under the Affordable Care Act than it would have been under prior law.

That estimate, notably, includes both individuals who will become newly eligible for Medicaid as a result of the expansion and millions of individuals who are *already* eligible under existing Medicaid standards, but who have not yet enrolled. See *id.* at 9-10 (citing CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* (June 16, 2010)). Petitioners are in no position to complain about the new enrollees in the latter category. States participating in Medicaid have agreed to ensure that "all individuals wishing to make application for medical assistance under the [State's Medicaid] plan shall have opportunity to do so." 42 U.S.C. 1396a(a)(8); see, *e.g.*, Florida Agency for Health Care Admin., *Florida KidCare Program: Amendment to Florida's Title XXI Child Health Insurance Plan Submitted to the Centers for Medicare and Medicaid Services* 17 (July 1, 2010) (lead petitioner Florida's representation to the federal government that Florida "has a strong historical commitment to Medicaid outreach" and that it has taken a number of steps to encourage eligible individuals to enroll in the program).

Within the Medicaid program itself, the Act fully maintains States' flexibility to reduce costs, whether through the design of the service delivery systems they rely on or through the rates they pay for care provided. See *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985). The Act offers States flexibility to design benefit packages for newly eligible individuals. See 42 U.S.C. 1396a(k)(1), 1396u-7(b) (describing "benchmark" and "benchmark-equivalent" coverage options). And the Act preserves flexibility for the States to choose whether to provide coverage for optional categories of beneficiaries and whether to offer optional benefits to both mandatory and optional beneficiaries.

Every State has elected to provide some optional coverage, which currently accounts for about 60% of total Medicaid spending. *Medicaid Enrollment and Expenditures* App. B, Tbl. 1, at 17 (summarizing spending on mandatory benefits for optional beneficiaries and optional benefits for all beneficiaries).[12] Many States, for example, have elected to extend Medicaid coverage to some "medically needy" individuals, *i.e.*, individuals whose incomes are too high or resources too great to qualify for coverage under Medicaid's mandatory eligibility categories, but who may qualify for optional coverage if their medical expenses are subtracted from their income. See 42 U.S.C. 1396a(a)(10)(C); *Pharmaceutical Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644, 651 & n.5 (2003); Kaiser Family Foundation, *Income Eligibility Requirements Including Income Limits and Asset Limits for the Medically Needy in Medicaid* (2009). A

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[12] See also *Budget Outlook* 39 (same percentage in 2001) (citing Kaiser Comm'n on Medicaid and the Uninsured, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* 11 (June 2005)).

State may choose to exercise the ability to cover medically needy individuals to fund, for example, nursing-home care for elderly individuals the State is not required to cover. In 2007, the elderly accounted for 44% of all spending on optional enrollees, and long-term care services accounted for 57% of spending for all optional enrollees. See *Medicaid Enrollment and Expenditures* Fig. 3, at 2. As a general rule, a State enjoys considerable flexibility to reduce optional spending if it determines that its fiscal circumstances require it.

The maintenance-of-effort provision noted by petitioners (Br. 8-9) does require States on an interim basis to maintain their current "eligibility standards, methodologies, or procedures." 42 U.S.C. 1396a(a)(74), 1396a(gg). But that requirement will expire with respect to adults when the new health insurance exchanges to be established pursuant to the Affordable Care Act are operational in 2014, and with respect to children in 2019. 42 U.S.C. 1396a(gg)(1) and (2). In the meantime, a State that submits a certification to the Secretary that it has, or is projected to have, a budget deficit is exempt from the requirement with respect to adults with incomes above 133% of the federal poverty level who are not pregnant or disabled. 42 U.S.C. 1396a(gg)(3). And even while it remains in effect, the maintenance-of-effort provision does not impair a State's ability to adjust provider payment rates or drug pricing, or to redesign delivery systems to provide care more efficiently, nor does it prevent a State from reducing spending on optional *services* for individuals covered by the state plan. Thus, States retain flexibility to offset increased obligations even during the period up to 2014.[13]

2. *A State's reluctance to turn down federal Medicaid funding does not authorize it to disregard the terms and conditions of the Medicaid program*

Petitioners contend (Br. 39-42) that the Affordable Care Act's changes to the Medicaid program represent an "extreme and unprecedented abuse" of power, *id.* at 23, because failure to comply jeopardizes a State's continued ability to receive federal Medicaid funds. That argument runs headlong into the fundamental principle, repeatedly recognized by this Court, that a State that accepts federal Medicaid funds must agree to administer a state plan that meets the federal standards on which Congress has conditioned its offer of funding assistance. See, *e.g.*, *Harris*, 448 U.S. at 308. Petitioners' contention that a State's reluctance to turn down federal Medicaid grants entitles it to disregard the program's basic terms and conditions finds no support in this Court's cases, has no logical stopping point, and misconceives fundamental constitutional principles.

a. In recognizing Congress's authority to attach conditions to the appropriation of money from the Treasury, this Court has explained that the exercise of that authority, unlike a directive to the States to enact or implement a federal regulatory program, leaves to "the residents of the State" the "ultimate decision as to whether or not the State will comply. *New York*, 505 U.S. at 166-167. If a State's citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant." *Id.* at 168.

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[13] Petitioners note in passing that Section 2304 of the Affordable Care Act amended the Medicaid Act's definition of "medical assistance" to include "care and services themselves." See States' Br. 9. Petitioners have previously taken the view that the contours of this amendment are "unclear," that they "cannot be assessed until regulations are promulgated," and that the provision is "thus not amenable to cost projections." Mem. in Support of Pls. Mot. for Summ. J. 42 n.42 (Docket entry No. 80). In any event, legislative history indicates that the provision was intended to clarify, rather than change, existing law. See H.R. Rep. No. 299, 111th Cong., 1st Sess. Pt. 1, 649-650 (2009).

In nonetheless arguing that the conditions Congress has attached to federal Medicaid funds are unconstitutionally coercive, petitioners rely on this Court's observation in *Dole* that prior "decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" 483 U.S. at 211 (quoting *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 589-590 (1937)); see States' Br. 27. But in rejecting the State's coercion challenge to a condition of a federal highway grant in that case, the Court observed that every financial incentive "is in some measure a temptation," and that "to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 589-590). In *Steward Machine* itself, the Court rejected an argument that the federal government had deployed "the whip of economic pressure" to coerce States into enacting unemployment compensation laws. 301 U.S. at 587. Expressing doubt as to whether the concept of "undue influence" "can ever be applied with fitness to the relations between state and nation," the Court explained that the law "has been guided by a robust common sense which assumes the freedom of the will as a working hypothesis." *Id.* at 589-590.

Applying these principles, the courts of appeals have uniformly rejected arguments that conditions on participation in Medicaid and other spending programs are unconstitutionally "coercive" because a State may be reluctant to turn down federal funding. See, *e.g.*, *Van Wyhe* v. *Reisch*, 581 F.3d 639, 652 (8th Cir. 2009) (federal grant for state prisons), cert. denied, 130 S. Ct. 3323 (2010); *Jim C.* v. *United States*, 235 F.3d 1079, 1082 (8th Cir. 2000) (en banc) (federal education grant), cert. denied, 533 U.S. 949 (2001); *Kansas* v. *United States*, 214 F.3d 1196, 1203-1204 (10th Cir.) (federal welfare grant), cert. denied, 531 U.S. 1035 (2000); *California* v. *United States*, 104 F.3d 1086, 1092 (9th Cir.) (Medicaid grant), cert. denied, 522 U.S. 806 (1997); *Padavan* v. *United States*, 82 F.3d 23, 28-29 (2d Cir. 1996) (Medicaid grant); *Nevada* v. *Skinner*, 884 F.2d 445, 448-449 (9th Cir. 1989) (federal highway grant), cert. denied, 493 U.S. 1070 (1990); *Oklahoma* v. *Schweiker*, 655 F.2d 401, 413-414 (D.C. Cir. 1981) (Medicaid grant) (*Schweiker*).[14]

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[14] The Fourth Circuit's decision in *Madison* v. *Virginia*, 474 F.3d 118, 128 (2006), on which petitioners rely (Br. 46, 58), did not depart from these principles. The court of appeals in that case rejected Virginia's challenge to the funding conditions established by the Religious Land Use and Institutionalized Persons Act of 2000, 42 U.S.C. 2000cc *et seq.*, but stated in dictum that "[f]ederal statutes that threaten the loss of an entire block of federal funds upon a relatively minor failing by a state are constitutionally suspect." *Madison*, 474 F.3d at 128 (quoting *West Va.* v. *United States Dep't of Health & Human Servs.*, 289 F.3d 281, 291 (4th Cir. 2002)). Even accepting the Fourth Circuit's dictum for purposes of argument, it provides no basis to question the conditions established by the Affordable Care Act's amendments to the Medicaid program. Those conditions are not "minor"; they are, as petitioners have acknowledged, "core program requirements." Pet. 26.

As these courts have recognized, the size of a federal grant may make it less likely, as a practical matter, that a State will "view federal policy as sufficiently contrary to local interests" to warrant turning down the federal funds. *New York*, 505 U.S. at 168. But that doesn't mean that the federal government, simply by *offering*, has coerced the State into *accepting*. See, *e.g.*, *Jim C.*, 235 F.3d at 1082 ("Sovereign states are fully competent to make their own choice.").

Moreover, to decide whether any given federal grant was large enough to be impermissibly coercive under petitioners' position, courts would inevitably be thrust into the role of arbiters of conflicting policy judgments related to matters of state budgets and revenues and state assessments of the acceptability of various federal conditions. See *Schweiker*, 655 F.2d at 414 (courts "are not suited to evaluating whether the states are faced * * * with an offer they cannot refuse or merely a hard choice"); *Skinner*, 884 F.2d at 448 ("The difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments.").

In this case, for example, although petitioners ask the Court to invalidate the Affordable Care Act's amendments to Medicaid as impermissibly coercive, other state officials have defended the "Medicaid expansion as an affordable and preferable alternative to the costs that their states would have faced, without any federal assistance, to underwrite health insurance for poor, childless adults or to subsidize uninsured care for such populations."[15] A number of States in fact have already chosen to extend eligibility to the additional populations made eligible by the Affordable Care Act, even before the effective date for mandatory coverage and before the increased contribution rate is available.[16] Petitioners offer no metric by which a court could resolve the apparent disagreements among state officials about any assertedly "coercive" effect of a federal funding program without delving into essentially political questions about States' differing policy choices and budgetary priorities.

Nor would it enhance the autonomy and sovereignty of the States within our federal system over the long term to subject such matters to judicial determination by federal courts, rather than the politically accountable officials of the States and the United States. Quite the opposite. It is a central principle of our system of dual sovereignty that the United States and the States will exercise independent judgment concerning what spending measures will best promote the public welfare within their respective spheres. As part of that responsibility, each must decide for itself whether promotion of the general welfare would be best achieved by independent action, or instead by entering into a cooperative financial arrangement with the other. The Medicaid Act, since its inception and as amended by the Affordable Care Act, sets forth the terms and conditions under which Congress has offered to enter into such an arrangement and to furnish funds from the Treasury to assume what Congress has determined to be its fair share of the cost of providing needed medical care to low-income people in the States.

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[15] Governors Amicus Br. 13 (Docket entry No. 133); see also Amicus Br. of Oregon, Iowa, Vermont, Maryland, and Kentucky, supporting Def. Mot. for Summ. J. (Docket entry No. 130); Amicus Br. of State Legislators, supporting Def. Mot. for Summ. J. (Docket entry No. 126).

[16] California, for example, has obtained a waiver allowing it to begin covering individuals with income at or below 133% of the poverty line in advance of 2014. See California et al. Severability Amicus Br. 16.

Petitioners' arguments are impossible to square with these fundamental postulates. At bottom, what petitioners are contending is that it would be politically untenable for them to withdraw from Medicaid because their citizens would bridle at the resulting loss of medical services or the added tax burden needed to maintain these services. What petitioners describe as coercion is merely a reflection of the policy preferences of their own citizens. And what they seek is the ability to use the courts to tailor federal spending programs to their preferred specifications, and thereby avoid political accountability for the consequences that would follow from rejecting federal aid on the terms offered.

No principle of federalism confers on the States such unilateral authority to dictate the conditions under which funds appropriated by Congress will be spent, or to pick and choose among those conditions. To the contrary, the Spending Clause, the Appropriations Clause, and the Supremacy Clause foreclose recognition of such authority in the States. This Court has observed that cooperative federal-state programs enacted pursuant to the Spending Clause are "in the nature of a contract" between the federal government and the State. *Pennhurst*, 451 U.S. at 17; see *Arlington Cent. Sch. Dist. Bd. of Educ.* v. *Murphy*, 548 U.S. 291, 296 (2006). Viewing petitioners' claim through that lens, the terms and conditions embodied in the Medicaid Act, both at its inception and as amended by the Affordable Care Act, constitute the offer by the United States to enter into or maintain a contractual relationship with the States. The States are free to accept or reject that offer, but they have no right to insist that Congress change its offer to make it more acceptable to the States.

b. Petitioners contend (Br. 39-40) that the extension of Medicaid eligibility in the Affordable Care Act is uniquely coercive because of the "unparalleled" size of federal Medicaid grants, and because of the possibility that failure to adhere to the new standards may "put at risk pre-existing funding streams" on which States have come to depend. But the features petitioners describe were not newly introduced by the Affordable Care Act. The Medicaid program has long been the largest federal grant-in-aid program. See *Schweiker*, 655 F.2d at 403. It has long had both mandatory and optional features. And the program has grown as a consequence of the decisions States themselves have made not only to remain in the program over time but also to take advantage of its optional features and the additional federal funds associated with those options. Nothing in that experience supports the conclusion that the extension of Medicaid eligibility in the Affordable Care Act is unconstitutionally coercive.

It would be a perverse result if, having voluntarily sought substantially increased Medicaid funding from the federal government (especially by expanding optional coverage), a State could then turn around and claim that the amount of the funding it has chosen to accept has—by the very fact of that acceptance—become a basis for blocking any change in the terms and conditions on which Congress is prepared to continue furnishing financial assistance. Yet that is precisely what petitioners contend. No principle of Our Federalism requires that a State's participation in a federal funding program gives rise to a right unilaterally to alter the conditions on which federal funds will be paid out of the Treasury under the program going forward.

Indeed, petitioners' argument cannot be reconciled with this Court's decision in *OPM* v. *Richmond*. There, the Court held that there can be no claim of estoppel, based on asserted misrepresentations by federal employees, to obtain funds from the federal Treasury under a federal benefits program on terms different than those prescribed by Congress in the governing statute. 496 U.S. at 419-424. The Court concluded that any such notion of estoppel would conflict with the exclusive power granted to Congress under the Appropriations Clause. *Id.* at 424-434. Petitioners' argument in this case is at bottom one of estoppel as well—that Congress, having offered a program of federal financial assistance with particular attributes, and the States having accepted, may not alter the basic eligibility standards under that program, but must instead give to the States an option whether to comply with the changed standards. It follows *a fortiori* from *OPM* v. *Richmond* that the Appropriations Clause allows no such principle of estoppel against the United States *as a constitutional matter* that would prevent Congress from altering the contours of the overall program. Indeed here, the asserted estoppel arises from the States' own voluntary action, not from any misleading by Congress. To the contrary, as we shall next explain, Congress could not have been clearer that it reserved the power to revise the program.

c. Petitioners suggest (Br. 37; see *id.* at 6 n.6) that the Congress that enacted the Affordable Care Act should have eliminated any risks to pre-existing funding streams by giving participating States the option to cover new categories of individuals rather than making their eligibility a mandatory term of Congress's offer of federal financial assistance. But it is not the case, as petitioners seem to suggest (*id.* at 37), that Congress has always given participating States a choice whether to cover new categories of individuals in exchange for additional federal funding. See pp. 5-7, *supra*. More fundamentally, under Medicaid as under other provisions of the Social Security Act, as well as other statutes enacted pursuant to the Spending Clause, it is "inevitable" that "amendment of its provisions would be necessary in response to evolving social and economic conditions." *Bowen* v. *Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 51 (1986). Congress's ability to make changes in any such program "is implicit in the institutional needs of the program." *Id.* at 52 (quoting *Flemming* v. *Nestor*, 363 U.S. 603, 611 (1960)).

In the Social Security Act, Congress has made its reservation of such power explicit, expressly reserving "the right to alter, amend, or repeal any provision" of that statute. 42 U.S.C. 1304. As the Court has explained with respect to this very provision, "the 'effect of these few simple words' has been settled since the *Sinking-Fund Cases*, 99 U.S. [9 Otto] 700 (1879)," *Public Agencies*, 477 U.S. at 53 (citation omitted): through such language, "Congress not only retains, but has given special notice of its intention to retain, full and complete power to make such alterations and amendments as come within the just scope of legislative power," *Sinking-Fund Cases*, 99 U.S. [9 Otto] at 720. Without defining "the limits of the reserved power," the Court in *Public Agencies* and the *Sinking-Fund Cases* thought it "'safe to say' that Congress had the authority to provide by amendment whatever rules it might 'have prescribed'" in its initial enactment. *Public Agencies*, 477 U.S. at 54 (quoting *Sinking-Fund Cases*, 99 U.S. at 721). Petitioners do not appear to dispute that Congress could have included in its initial enactment of the Medicaid Act the entire set of terms and conditions that will be in effect in 2014 following the amendments made by the Affordable Care Act. It therefore is "safe to say" that, by virtue of 42 U.S.C. 1304, Congress "had the authority to provide by amendment," *Public Agencies*, 477 U.S. at 54, the additional category of beneficiaries made eligible by the Affordable Care Act.

Petitioners acknowledge that they entered into the Medicaid program knowing they had no "vested right that the program would continue indefinitely or upon the same terms." States' Br. 41. Having done so, under statutory terms that have long been understood to reserve to Congress an authority to alter that is as broad as its power to enact, petitioners can claim no entitlement to continue participating in Medicaid and receiving federal Medicaid funds on "unaltered" terms. *Id.* at 42.

What is more, the Medicaid Act has always authorized the Secretary to withhold federal funding for noncompliance. Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 121(a), § 1904, 79 Stat. 351 (now codified at 42 U.S.C. 1396c). That authorization has always included the discretion to withhold either part or all of the entire federal grant. *Ibid.* (if the Secretary determines that a State has failed to comply with the terms of the program, the Secretary shall notify the State "that further payments will not be made to the State (*or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure*), until the Secretary is satisfied that there will no longer be any such failure to comply") (emphasis added); see Pet. App. 62a; cf. States' Br. 35 n.15, 37, 39-40. As a practical matter, the Secretary's withholding power remains largely untested: The federal government and the States alike have every incentive to resolve compliance issues to ensure that needy individuals continue to receive needed medical assistance, and petitioners identify no instance in which a participating State's Medicaid funding has been terminated for noncompliance. But the Secretary's power to insist on compliance is not new.

d. Petitioners' focus on the size of federal Medicaid grants also ignores other factors relevant to a State's decision to accept or reject federal funding. In petitioner's view, because "[c]oercion is measured by how much a State stands to lose if it *rejects* Congress' terms" in its offer of federal financial assistance, States' Br. 46, it is immaterial that Congress has taken on the lion's share of the cost of funding medical assistance for the additional category of needy state residents. In petitioners' view, the generous terms of the federal government's offer can only make the offer *more* coercive: "If the ACA offered States double the amount of their Medicaid expenditures if they would accept the new conditions, that double or nothing offer * * * would make the offer harder, not easier, to refuse, and would render any notion of meaningful choice that much more illusory." *Id.* at 47. On petitioners' through-the-looking-glass theory, the better the bargain for the State, the more reason to conclude that the State has been impermissibly "coerced" into accepting it. Presumably, the Act's Medicaid eligibility expansion would have been even more coercive Congress chosen to fund indefinitely 100% of all its costs. That cannot possibly be the law.

And petitioners offer no guidance for determining when States have become sufficiently helpless in their dependency that they can no longer exercise their autonomy as sovereigns to decline participation in a federal program.

In any event, this is not a case in which the federal government has offered a State substantial sums that are unrelated to or far in excess of the costs of the federally funded program in order to induce the State to take particular action—particularly action that is only marginally related to the federal purpose. Here, Congress has chosen to fund a greater proportion (but still less than 100%) of the costs of the very program that the federal government has offered to support. It would be an exceedingly odd notion that, in a program like Medicaid, which is in the nature of a contract, one party (the State) would have a cognizable claim that the other party (the United States) is offering *too much* consideration for the former's acceptance and performance of the contract.

e. Petitioners suggest that conditions on the receipt of Medicaid funding are constitutionally suspect because the federal government's revenues are drawn from States' "own taxpayers." States' Br. 44. They thus argue that "[t]he choice given States is the equivalent of that offered by a pickpocket who takes a wallet and gives the true owner the 'option' of agreeing to certain conditions to get the wallet back or having it given to a stranger." *Ibid.*

Invocation of that unfortunate analogy does a serious disservice to the worthy undertaking by Congress and the States (including the petitioner States themselves) over time to furnish needed health care to those who cannot afford it. More fundamentally, however, it rests on a serious misconception of our Constitution's structure. Federal taxpayers are not merely citizens of the States; they "are also citizens of the United States." *Massachusetts* v. *Mellon*, 262 U.S. 447, 485 (1923). Under Article I, Section 8 of the Constitution and the Sixteenth Amendment, Congress taxes the citizens of the United States directly. Cf. *New York*, 505 U.S. at 165 (explaining that, under our constitutional framework, Congress "exercise[s] its legislative authority directly over individuals rather than over States").[17]

The people in a State are the State's "own taxpayers" when the State itself taxes the people. The national government does not depend for its support on either the States themselves or a share of the revenues that citizens of the States pay to the States in taxes. And the independent authority of the States to tax and spend in no way detracts from the power of Congress to levy *federal* taxes and to appropriate money in the *federal* Treasury. As is true under the Commerce Clause, Congress's power to levy taxes and spend for the general welfare "can neither be enlarged nor diminished by the exercise or non-exercise of state power." *Gonzales* v. *Raich*, 545 U.S. 1, 29 (2005) (quoting *United States* v. *Darby*, 312 U.S. 100, 114 (1941)). Petitioners' contrary view would cast doubt on every conditional federal grant, allowing a State, in every case, to claim that it was impermissibly coerced into accepting federal funds to avoid having federal tax dollars diverted to "stranger[s]."

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[17] Petitioners' professed concern for state taxpayers is hard to square with their request that this Court invalidate hundreds of billions of dollars of federal premium tax credits authorized by the Affordable Care Act. See States' Br. 54 n.18 (arguing that the Court should invalidate the Affordable Care Act in its entirety if it concludes that the Medicaid eligibility expansion is unconstitutional); States' Severability Br. 42-59; see also *CBO's March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act* 14, Tbl. 2 (Mar. 18, 2011) (estimating that, between 2012 and 2021, premium tax credits and related spending will cost the federal government $777 billion).

There is similarly no merit to petitioners' contention (Br. 50-52) that the federal government acts coercively if it uses money collected through taxation to fund a spending program without dedicating "equivalent funds" to States that have opted out of the program.[18]

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[18] Petitioners point to what they characterize as the "staggering $110 billion" collected from Florida residents by the federal government in 2009. States' Br. 44. Putting aside the fact that the figure represents gross collections (after refunds it was approximately $85 billion, IRS, *Data Book, 2009*, Tbl.5, at 12 (listing gross collections), Tbl. 8, at 19 (listing refunds) (2010)), petitioners fail to mention that, according to U.S. Census data, Florida was the recipient of approximately $181 billion in federal revenues that year. U.S. Census Bureau, *Consolidated Federal Funds Report for Fiscal Year 2010*, Tbl. 13, at 26 (2011) (providing historical spending data by State). Thus, had Florida withdrawn from Medicaid in 2009, the fiscal consequence would have been that the net subsidy its residents received from taxpayers in other States of the Union would have been somewhat less. To be sure, 2009 was an unusual year because of the severe economic downturn. But a comparison of federal expenditures and federal tax collections from 1981 to 2005 reveals that Florida more often than not received more revenue than it paid in federal taxes. The Tax Foundation, *Federal Taxes Paid vs. Federal Spending Received by State, 1981-2005* (2007). Most of the petitioner States likewise received more in revenue than they paid in federal taxes in most years during that span. *Ibid.* Even more importantly, these figures illustrate the implausibility of measuring "coercion" by comparing what residents of a State pay in federal taxes and the federal revenues the State receives. On petitioners' logic, States such as Texas or California, whose residents typically pay more in federal taxes than the States receive in federal revenues, see *ibid.*, could claim "coercion" every time Congress included a new condition on a federal spending measure.

Certainly *Steward Machine*, on which petitioners rely (*ibid.*), stands for no such principle. In *Steward Machine*, Congress had enacted the federal unemployment tax in order to encourage States "to contribute [their] fair share to the solution" of a national employment crisis that had imposed a "disproportionate" and "mountainous" burden on the federal government in furnishing relief to the people affected. 301 U.S. at 588. The Court explained that the unemployment provisions of the Social Security Act were "an attempt to find a method by which all these public agencies may work together to a common end." *Ibid.* The Court further observed that "[e]very dollar of the new taxes will continue in all likelihood to be used and needed by the nation as long as states are unwilling, whether through timidity or for other motives, to do what can be done at home." *Id.* at 588-589. "At least," the Court continued, "the inference is permissible that Congress so believed, *though retaining undiminished freedom to spend the money as it pleased.*" *Id.* at 589 (emphasis added).

As the emphasized language demonstrates, nothing in *Steward Machine* suggests that a particular State has the right to demand that the Congress of the United States appropriate federal funds derived from federal taxes for the benefit of the State's residents, regardless of whether the State agrees to comply with conditions attached to the appropriation made to address a national problem. To the contrary, in a decision issued on the same day as *Steward Machine*, the Court made clear that it "is not a valid objection" to a tax "that those who pay the tax * * * may not be benefited by the expenditure." *Carmichael* v. *Southern Coal & Coke Co.*, 301 U.S. 495, 521 (1937); see *id.* at 522 (a tax is not an "assessment of benefits," but "a means of distributing the burden of the cost of government"); accord *Commonwealth Edison Co.* v. *Montana*, 453 U.S. 609, 622-623 (1981) (quoting *Carmichael*).

f. Although petitioners purport to mount a challenge limited to the extension of Medicaid eligibility in the Affordable Care Act, States' Br. 53-59, the logic of their arguments would appear to apply to the categories of eligible individuals and benefits Congress has required to be covered in the past. Petitioners do not explain whether longstanding Medicaid requirements, like the requirement to cover poor children, *e.g.*, 42 U.S.C. 1396a(10)(A)(i)(VI), or to cover inpatient hospital services, 42 U.S.C. 1396d(a)(1), or to comply with federal civil rights laws, *e.g.*, 42 C.F.R. Pt. 80, have been coercive all along or have become coercive over time as Medicaid spending has grown.

Nor are the implications of petitioners' theory limited to Medicaid. Petitioner Florida, for instance, in 2008 received $728 million under Title I of the Elementary and Secondary Education Act of 1965, 20 U.S.C. 6301 *et seq.*, as amended by the No Child Left Behind Act of 2001, Pub. L. No. 107-110, 115 Stat. 1425, a program whose purpose is to improve the achievement of low-achieving students who attend high-poverty schools.[19] Congress has conditioned a state educational agency's receipt of Title I funding on the agency's compliance with federal requirements designed to further this purpose. See 20 U.S.C. 6301 *et seq.*; see also *Horne* v. *Flores*, 129 S. Ct. 2579, 2601 (2009). In addition, state education programs that accept federal funds must comply with the requirements established by federal statutes such as Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Family Educational Rights and Privacy Act of 1974.[20] Petitioners observe that federal Medicaid grants are generally larger than other federal grants, States' Br. 56, but offer no principled basis for deciding whether other grants, too, might be large enough that the Constitution would require invalidation of the conditions Congress has attached to them.

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[19] See Department of Education, *State Funding History Tables By State*, http://www2.ed.gov/about/overview/budget/history/sthistbyst01to08.pdf.

g. Finally, the basic flaws in petitioners' position are underscored by considering steps Congress unquestionably could take, even under petitioners' view, that are directly parallel to the steps Congress *did* take. First, there can be no doubt that Congress could repeal outright the Medicaid program as it currently exists, despite whatever expectations concerning continuation of the program the States might have. Second, it is clear, and petitioners appear to concede, that Congress constitutionally could have enacted the Medicaid program at the outset in one statute that contained all of the features of the program as it will exist when the amendments made by the Affordable Care Act become effective in 2014. Third, there is no reason why Congress could not repeal the Medicaid program entirely and establish a new program—containing all of these features and taking effect in 2014—for helping to fund the States in furnishing medical assistance to low-income individuals. See *Gray Panthers*, 453 U.S. at 37-38 (discussing the replacement of three welfare benefits programs with SSI). And fourth, if Congress had repealed Medicaid and established such a new program to take effect in 2014, Congress could have provided a transitional program for the interim period to provide for some continuation of benefits. In substance, this is what Congress did in the Affordable Care Act, albeit by amending the Medicaid Act rather than repealing it and enacting a new program to take effect four years later, with a transitional program in the interim. If each of the separate measures described above would be constitutional, as it surely would be, there is nothing to render them unconstitutional when considered together and as changes to an existing program.

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[20] See *Board of Educ. of Westside Cmty. Schs.* v. *Mergens*, 496 U.S. 226, 241 (1990) (noting that because the Equal Access Act "applies only to public secondary schools that receive federal financial assistance, * * * a school district seeking to escape the statute's obligations could simply forgo federal funding. Although we do not doubt that in some cases this may be an unrealistic option, Congress clearly sought to prohibit schools from discriminating on the basis of the content of a student group's speech, and that obligation is the price a federally funded school must pay if it opens its facilities to noncurriculum-related student groups.").

3. There is no merit to petitioners' contention that various provisions of the Affordable Care Act reflect an acknowledgment by Congress that the Medicaid eligibility extension is impermissibly coercive

Petitioners acknowledge, with considerable understatement, that their suggested "line between coercion and persuasion may not be bright." States' Br. 30. But they argue that whatever difficulties the Court may encounter in other cases, the Affordable Care Act crosses that line because Congress itself expected the States to remain in the Medicaid program, as evidenced by its decision to "t[ie] Medicaid to the individual mandate" and its failure to provide a fallback option in case States opted out. *Id.* at 33; see *id.* at 33-39. Petitioners' characterization of the Affordable Care Act is incorrect, and petitioners' reliance on their assessment of Congress's expectations is in any event misconceived.

a. Petitioners err in asserting that the extension of Medicaid eligibility was designed to provide a means of supplying health insurance coverage to low-income individuals "forced to obtain coverage by the [Affordable Care Act] and its individual mandate." States' Br. 34-35. The minimum coverage provision does not "force[]" low-income individuals to obtain health insurance coverage. Indeed, the provision does not "force[]" *anyone* to obtain coverage. It instead provides that, beginning in 2014, applicable individuals who fail to maintain a minimum level of health coverage for themselves or their dependents will owe a tax penalty for each month in the tax year during which minimum coverage is not maintained. 26 U.S.C. 5000A; see Gov't Minimum Coverage Br. 59-62.

Moreover, individuals who are not required to file a federal income tax return for a given year are exempt from the penalty. 26 U.S.C. 5000A(e)(2).[21] Congress also exempted individuals whose premium payments would exceed 8% of their household income, 26 U.S.C. 5000A(e)(1) (exemption for "Individuals who cannot afford coverage"),[22] and Congress authorized the Secretary of HHS to exempt other individuals who are determined by the Secretary "to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan," 26 U.S.C. 5000A(e)(5). Congress manifestly did not expect low-income individuals to enroll in Medicaid for the purpose of avoiding a minimum coverage penalty from which low-income individuals who cannot afford health insurance would be exempt.

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[21] As noted above, note 8, *supra*, generally, for 2011, the threshold for filing an income tax return is $9500 in gross income for a single taxpayer under the age of 65; $12,200 for a head of household under 65; and $19,000 for a married couple under 65 filing jointly.

[22] As noted above, note 5, *supra*, except in Alaska and Hawaii, the federal poverty level in 2010 was $10,830 for one person. Based on that figure, 8% of the income of an individual at the upper end of the range covered by the Affordable Care Act's extension of Medicaid eligibility (133% of the federal poverty level, plus a 5% income disregard, see *ibid.*) would be $1195.

b. Nor is it relevant for constitutional purposes that Congress did not provide a "contingency plan" in the event a State decided to terminate its participation in the Medicaid program. The federal share of the cost of the expanded coverage under the Affordable Care Act's Medicaid amendments is far greater than under the Medicaid program generally, funding at least 90% of the costs of furnishing medical assistance for newly eligible individuals. Congress was aware that all States have participated in Medicaid for decades and that all of the participating States have chosen to provide far more expansive coverage than the Medicaid Act requires. It is therefore unsurprising that Congress anticipated that the States would choose to accept the exceedingly generous federal assistance for the benefit of the States' own residents in need of health care, and therefore did not provide a comprehensive fallback provision for individuals in the event the States in which they resided chose not to participate in Medicaid. By contrast, the Affordable Care Act's provisions for States to establish insurance exchanges if they choose to do so, to which petitioners point (Br. 35), did not build on longstanding, widespread experience among the States. It therefore is equally unsurprising that Congress did provide a fallback mechanism allowing the federal government to establish an insurance exchange if the State chose not to do so.[23]

Whatever Congress's expectations about States' continued participation in Medicaid might have been, however, States remain free to frustrate those expectations by adopting the "'simple expedient' of not yielding to what [they] urge[] is federal coercion." *Oklahoma* v. *United States Civil Serv. Comm'n*, 330 U.S. at 143-144 (citing *Mellon*, 262 U.S. at 482). If one or more States elect to withdraw from Medicaid, Congress has the authority to adjust other programs accordingly. Congress's perceived expectations have no bearing on the question whether Congress has unconstitutionally coerced the States to participate in Medicaid.

c. Rejecting petitioners' argument does not mean, as petitioners would have it, "abandoning the very framework of our system of constitutional governance." States' Br. 32. To decide this case it suffices to conclude that Congress has not exceeded the structural limitations of our system of dual sovereignty by requiring States that choose to accept Congress's offer of federal financial assistance under the Medicaid program to comply with Congress's specification of the core elements that define the minimum scope of that program, including the category of needy individuals for whom Congress has chosen to make its assistance available. To accept petitioners' argument would, on the other hand, violate our constitutional structure by allowing a State to ignore the terms on which Congress has appropriated public funds from the Treasury in pursuit of the general welfare.

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[23] Cf. States' Br. 35-36 (discussing special rule authorizing federal premium tax credits for certain low-income individuals ineligible for Medicaid because of their alien status).

C. There Is No Basis To Believe That Congress Would Have Wanted The Entire Affordable Care Act To Fall If The Extension Of Medicaid Eligibility In Non-Consenting States Were Invalidated

In a footnote, petitioners assert that, if the extension of mandatory Medicaid eligibility were held unconstitutional, the entire Act should be declared a nullity. States' Br. 54 n.18. Because the Act's provision for the extension of Medicaid eligibility is constitutional, there is no reason to address that argument. The argument is not, in any event, properly presented in this case. The Affordable Care Act is multi-faceted legislation that contains numerous provisions addressing a wide variety of subjects beyond the extension of Medicaid eligibility, the great majority of which have no application to petitioners. This Court should not consider the validity of provisions of the Act that are not directed to petitioners but do affect numerous persons not before the Court. See Gov't Severability Br. 14-25.

Even if petitioners' sweeping severability argument were properly presented, there would be no basis to invalidate more of the Affordable Care Act amendments to the Medicaid Act than necessary to remedy the asserted violation. The severability clause in Chapter VII of Title 42 (which includes the Medicaid Act, 42 U.S.C. 1396 *et seq.*), provides: "If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby." 42 U.S.C. 1303. Should this Court conclude that the "application" of the extension of Medicaid eligibility is unconstitutionally coercive as applied to States that do not want to accept that portion of Congress's offer of federal financial assistance, the appropriate remedy, as directed by 42 U.S.C. 1303, would be to enjoin the "application" of the provision to unconsenting States and otherwise to permit the eligibility extension to function as written. Cf. *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 331 (2006) (indicating that a similar injunction may have been an appropriate remedy in light of a similarly worded severability provision).[24] There is no basis to believe that Congress would have preferred no Medicaid eligibility extension at all to an eligibility extension that applies only to consenting States. Far less is there any basis to believe that, having enacted the Affordable Care Act against the background rule of severability in the Social Security Act, Congress would have preferred invalidation of the Affordable Care Act in its entirety to relief that was directly tailored to the finding of a constitutional violation in one of the amendments it made to the Social Security Act.

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[24] Petitioners concede (Br. 47-48, 50) that the Act's provisions for expansion of Medicaid eligibility to additional populations are constitutional as applied to consenting States.

CONCLUSION

The judgment of the court of appeals upholding the Medicaid eligibility expansion should be affirmed.

Respectfully submitted.

DONALD B. VERRILLI, JR.
Solicitor General
TONY WEST
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
BETH S. BRINKMANN
Deputy Assistant Attorney General
LEONDRA R. KRUGER
Assistant to the Solicitor General
MARK B. STERN
ALISA B. KLEIN
Attorneys

GEORGE W. MADISON
General Counsel
Department of the Treasury
Washington, D.C. 20220

M. PATRICIA SMITH
Solicitor of Labor
Department of Labor
Washington, D.C. 20210

WILLIAM B. SCHULTZ
Acting General Counsel
KENNETH Y. CHOE
Deputy General Counsel
Department of Health and Human Services

FEBRUARY 2012

APPENDIX

1. U.S. Const. Art. I, § 8, Cl. 1 provides, in pertinent part:

> The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States[.]

2. U.S. Const. Art. I, § 9, Cl. 7 provides:

> No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law; and a regular Statement and Account of the Receipts and Expenditures of all public Money shall be published from time to time.

3. 26 U.S.C. 5000A (Supp. IV 2010) provides:

Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment.—

> **(1) In general.**—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more

months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) **Inclusion with return.**—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) **Payment of penalty.**—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) **Amount of penalty.**—

(1) **In general.**—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) **Monthly penalty amounts.**—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) **Flat dollar amount.**—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) **Percentage of income.**—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) **Applicable dollar amount.**—For purposes of paragraph (1)—

(A) **In general.**—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) **Phase in.**—The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) **Special rule for individuals under age 18.**—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) **Indexing of amount.**—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(4) **Terms relating to income and families.**—For purposes of this section—

(A) **Family size.**—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) **Household income.**—The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) **Modified adjusted gross income.**—The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

[(D) **Repealed**. Pub. L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(d) **Applicable individual.**—For purposes of this section—

(1) **In general.**—The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) **Religious exemptions.**—

(A) **Religious conscience exemption.**—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) **Health care sharing ministry.**—

(i) **In general.**—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) **Health care sharing ministry.**—The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) **Individuals not lawfully present.**—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) **Incarcerated individuals.**—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) **Exemptions.**—No penalty shall be imposed under subsection (a) with respect to—

(1) **Individuals who cannot afford coverage.**—

(A) **In general.**—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) **Required contribution.**—For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) **Special rules for individuals related to employees.**—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to[1] required contribution of the employee.

(D) **Indexing.**—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) **Taxpayers with income below filing threshold.**—Any applicable individual for any month during

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[1] So in original. Probably should be followed by "the".

a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) **Members of Indian tribes.**—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) **Months during short coverage gaps.**—

(A) **In general.**—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) **Special rules.**—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) **Hardships.**—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) **Minimum essential coverage.**—For purposes of this section—

(1) **In general.**—The term "minimum essential coverage" means any of the following:

(A) **Government sponsored programs.**—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;[2]

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans

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[2] So in original. The semicolon probably should be a comma.

Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) **Employer-sponsored plan.**—Coverage under an eligible employer-sponsored plan.

(C) **Plans in the individual market.**—Coverage under a health plan offered in the individual market within a State.

(D) **Grandfathered health plan.**—Coverage under a grandfathered health plan.

(E) **Other coverage.**—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) **Eligible employer-sponsored plan.**—The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) **Excepted benefits not treated as minimum essential coverage.**—The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) **Individuals residing outside United States or residents of territories.**—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) **Insurance-related terms.**—Any term used in this section which is also used in title I of the Pa-

tient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) **Administration and procedure.**—

(1) **In general.**—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) **Special rules.**—Notwithstanding any other provision of law—

(A) Waiver of criminal penalties.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) **Limitations on liens and levies.**—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

4. 42 U.S.C. 1303 provides:

Separability

If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby.

5. 42 U.S.C. 1304 provides:

Reservation of right to amend or repeal

The right to alter, amend, or repeal any provision of this chapter is hereby reserved to the Congress.

6. 42 U.S.C. 1396a (2006 & Supp. IV 2010) provides, in pertinent part:

State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37),[1] 606(h),[1] or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6)[1] of this title),

(II)(aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1396d(q) of this title), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase "the first day of the month following",

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (*l*)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (*l*)(2)(A) of this section for such a family;[2]

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[1] See References in Text note below.

[2] So in original. The semicolon probably should be a comma.

(V) who are qualified family members as defined in section 1396d(m)(1) of this title,

(VI) who are described in subparagraph (C) of subsection (*l*)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(B) of this section for such a family,

(VII) who are described in subparagraph (D) of subsection (*l*)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(C) of this section for such a family;[2] or

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved, subject to subsection (k);[3]

(ii) at the option of the State, to[4] any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to[4] any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

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[2] So in original. The semicolon probably should be a comma.

[3] So in original. Probably should be followed by "and".

[4] So in original. The word "to" probably should not appear.

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;[2]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the

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[2] So in original. The semicolon probably should be a comma.

State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title;[5]

(VIII) who is a child described in section 1396d(a)(i) of this title—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

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[5] So in original. The semicolon probably should be a comma.

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter;[5]

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);[5]

(X) who are described in subsection (m)(1) of this section;[5]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title;[5]

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals);[6]

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396*o* of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);[5]

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title;[6]

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;[6]

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[5] So in original. The semicolon probably should be a comma.

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);[6]

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State;[6]

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

(XIX) who are disabled children described in subsection (cc)(1);

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);[2]

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);[2] or

(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;

* * * * *

7. 42 U.S.C. 1396d provides in pertinent part:

Definitions

For purposes of this subchapter—

* * * * *

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to subsections (y), (z), and (aa) and section 1396u-3(d) of this title, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of Title 25). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures (other than expenditures under section 1396r-4 of this title) described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 1397dd of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title.

* * * * *

(y) Increased FMAP for medical assistance for newly eligible mandatory individuals

(1) Amount of increase

Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, shall be equal to—

(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

(D) 93 percent for calendar quarters in 2019; and

(E) 90 percent for calendar quarters in 2020 and each year thereafter.

(2) Definitions

In this subsection:

(A) Newly eligible

The term "newly eligible" means, with respect to an individual described in subclause (VIII) of section 1396a(a)(10)(A)(i) of this title, an individual who is not under 19 years of age (or such higher age as the State may have elected) and who, as of December 1, 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u-7(b)(1) of this title or benchmark equivalent coverage described in section 1396u-7(b)(2) of this title that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1396u-7(b)(1) of this title, or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

(B) Full benefits

The term "full benefits" means, with respect to an individual, medical assistance for all services covered under the State plan under this subchapter that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1396a(a)(10)(A)(i) of this title.

RESPONDENT'S BRIEF

Nos. 11-393 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.

STATE OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF FOR RESPONDENTS
(Severability)

DONALD B. VERRILLI, JR.
Solicitor General
Counsel of Record

TONY WEST
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

BETH S. BRINKMANN
Deputy Assistant Attorney General

JOSEPH R. PALMORE
Assistant to the Solicitor General

MARK B. STERN
ALISA B. KLEIN
ANISHA DASGUPTA
DANA KAERSVANG
Attorneys

Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

GEORGE W. MADISON
General Counsel
Department of the Treasury
Washington, D.C. 20220

M. PATRICIA SMITH
Solicitor of Labor
Department of Labor
Washington, D.C. 20210

WILLIAM B. SCHULTZ
Acting General Counsel

KENNETH Y. CHOE
Deputy General Counsel
Department of Health and Human Services
Washington, D.C. 20201

QUESTION PRESENTED

The minimum coverage provision of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, provides that, beginning in 2014, nonexempted federal income taxpayers who fail to maintain a minimum level of health insurance for themselves or their dependents will owe a penalty, calculated in part on the basis of the taxpayer's household income and reported on the taxpayer's federal income tax return, for each month in which coverage is not maintained in the taxable year. 26 U.S.C. 5000A (Supp. IV 2010).

The question presented is whether other provisions of the Act would be severable from the minimum coverage provision in the event the minimum coverage provision were declared unconstitutional.

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In the Supreme Court of the United States

No. 11-393

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.

No. 11-400

STATE OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF FOR RESPONDENTS
(Severability)

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-273a[1]) is reported at 648 F.3d 1235. The district court's opinion on the federal government's motion to dismiss

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[1] All citations are to the appendix to the federal government's certiorari petition in 11-398.

(Pet. App. 394a-475a) is reported at 716 F. Supp. 2d 1120. The district court's opinion on the parties' cross-motions for summary judgment (Pet. App. 274a-368a) is reported at 780 F. Supp. 2d 1256. The district court's order entering a stay of its declaratory judgment (Pet. App. 369a-393a) is reported at 780 F. Supp. 2d 1307.

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2011. The petitions for a writ of certiorari were filed on September 27 and 28, 2011, and were granted on November 14, 2011. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

Pertinent statutory provisions are set forth in the appendix to this brief.

STATEMENT

A. Statutory Background

Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act, Act, or ACA),[2] to expand access to affordable health care, and to improve the functioning of the national market for health care by regulating the terms on which insurance is offered, controlling costs, and rationalizing the timing and method of payment for health care services. The Act also contains numerous provisions concerning other aspects of health care and a variety of other subjects.

1. For decades, the federal government has made employer-sponsored health coverage more affordable

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[2] Amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029.

through favorable tax treatment. In particular, employees generally do not include as income and pay taxes on employers' payments of their health insurance premiums, unlike most other forms of employee compensation. 26 U.S.C. 106 (2006). The Affordable Care Act expands the availability of employer-based insurance. Since January 1, 2010, the Act has provided tax credits for eligible small businesses to further subsidize employee health coverage. See 26 U.S.C. 45R.[3] In addition, beginning in 2014, the Act's employer responsibility provision will impose a tax liability under specified circumstances on large employers that do not offer adequate coverage to full-time employees. 26 U.S.C. 4980H.

2. Congress has repeatedly expanded eligibility for Medicaid to increase access to health care. As a result, between 1966 and 2008, Medicaid enrollment increased from four million to 47.6 million. Centers for Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs. (HHS), *2010 Actuarial Report on the Financial Outlook for Medicaid* 19 (2010) (Tbl. 3); see Teresa A. Coughlin et al., *Medicaid Since 1980: Costs, Coverage, and the Shifting Alliance Between the Federal Government and the States* 2, 47-55 (1994). Building on this tradition, Congress in the Affordable Care Act again expanded eligibility for Medicaid. Beginning in 2014, Medicaid eligibility will extend to individuals who have household income up to 133% of the federal poverty level and are not eligible for Medicare based on age or disability. 42 U.S.C. 1396a(a)(10)(A)(i)(VIII). The Congressional Budget Office (CBO) has projected that this eligibility expansion, by itself, will increase Medicaid

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[3] Unless otherwise noted, all citations to the United States Code refer to Supp. IV 2010, and all citations to the United States Code Annotated refer to Supp. 2011.

enrollment by 9-10 million between 2010 and 2019. See Letter from Douglas Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, House of Representatives 9 (Mar. 20, 2010); CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010) (*CBO's June 2010 Analysis*).

3. The Act provides for creation of health insurance exchanges in 2014 to enable individuals and small businesses to leverage their collective buying power to obtain health insurance at rates competitive with those charged for typical large employer plans. 42 U.S.C.A. 18031-18044.

4. Although federal tax law has long subsidized employer-sponsored health insurance (see pp. 2-3, *supra*), with limited exceptions, health insurance purchased in the individual market has not received favorable tax treatment. CBO, *Key Issues in Analyzing Major Health Insurance Proposals* 9 (2008) (*Key Issues*). The Affordable Care Act will address that imbalance by providing tax subsidies. Beginning in 2014, individuals with household income up to 400% of the federal poverty level can receive federal premium tax credits to help them purchase insurance through a health insurance exchange. 26 U.S.C. 36B. For eligible individuals with incomes up to 250% of the federal poverty level, the Act also authorizes federal payments to insurers to help cover individuals' cost-sharing expenses (such as copayments or deductibles) associated with coverage obtained through an exchange. 42 U.S.C.A. 18071(c)(2).

5. The Act adopts a number of market reforms that will increase access to health care services by removing barriers to affordable health insurance coverage.

a. Many of the Act's insurance reforms have already taken effect. For example, insurers can no longer rescind coverage absent fraud or intentional misrepresentation on the part of a policyholder. 42 U.S.C. 300gg-12. Insurers may no longer impose lifetime dollar limits on essential benefits and are subject to restrictions on imposition of annual dollar limits. See 42 U.S.C. 300gg-11(a)(1)(A) and (B).[4] In addition, insurers must provide rebates if their medical loss ratios—*i.e.*, the percentage of premium revenues spent on clinical services and activities that improve health care quality, as opposed to administrative costs or profits—are below specified levels. See 42 U.S.C. 300gg-18(b). The Act also generally requires insurers providing family coverage to cover adult children until age 26. 42 U.S.C. 300gg-14. An additional 2.5 million young adults have gained coverage under this provision. See Office of the Assistant Sec'y for Planning & Evaluation (ASPE), HHS, *ASPE Issue Brief: 2.5 Million Young Adults Gain Health Insurance Due to the Affordable Care Act* (2011).

b. Additional market reforms will take effect in 2014. Before the Affordable Care Act, the federal government regulated employer-based health coverage under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936. See Gov't Minimum Coverage Br. 5 (discussing anti-discrimination provisions in those statutes). Prior law generally did not, however, prevent insurers in the individual market from varying premiums, or denying coverage altogether, based on the medical condition or history of an individual or an individual's dependent. Free of such regulatory constraints, insurers in the individual market have denied coverage or charged higher rates if individuals or their dependents have any of a variety of common medical conditions. See *id.* at 5-6.

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[4] The Act will eventually eliminate annual dollar limits on benefits in most plans, but provides that the Secretary of HHS may establish "restricted annual limits" in the meantime. 42 U.S.C. 300gg-11(a)(1)(B) and (2); see 45 C.F.R. 147.126(d) (increasing minimum annual limits each year until they are eliminated in 2014).

The Act fills the gap in the federal regulatory scheme by barring insurers from denying coverage to any individual because of the medical condition or history of the applicant or applicant's dependents. See 42 U.S.C. 300gg-1, 300gg-3, 300gg-4(a). This feature of the Act is known as "guaranteed issue."[5] The Act also will bar insurers from charging individuals higher premiums because of such medical factors. 42 U.S.C. 300gg(a)(1), 300gg-4(b). This feature is known as "community rating."[6]

6. The Act also establishes new tax penalties to be paid by non-exempted individuals who do not maintain a minimum level of health coverage for themselves and

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[5] 42 U.S.C. 300gg-1 will generally require insurers to accept every employer and individual applying for coverage; 42 U.S.C. 300gg-3 will prohibit insurers from excluding coverage for preexisting conditions; and 42 U.S.C. 300gg-4(a) will bar insurers from basing eligibility on "health status-related factors." The prohibition on denying coverage based on preexisting conditions applies now with respect to individuals under age 19. See 42 U.S.C. 300gg-3 note (Effective Date of 2010 Amendment).

[6] 42 U.S.C. 300gg(a)(1) provides that premium rates can vary based only on: whether the coverage is for an individual or family; geographic location (known as a "rating area"); age (the ratio between the highest and lowest age-based rates cannot be greater than three to one); and tobacco use (the rate for such use cannot be more than 50% higher than non-tobacco use rates). 42 U.S.C. 300gg-4(b) prohibits insurers from charging higher premiums to similarly situated individuals and dependents within a group based on "health status-related factor[s]."

their dependents. 26 U.S.C. 5000A. Congress expressly found that this minimum coverage provision is crucial to the viability of the guaranteed-issue requirements that will take effect, along with the minimum coverage provision, in 2014. Congress determined that, without a minimum coverage provision, many individuals would take advantage of the guaranteed-issue and community-rating requirements by "wait[ing] to purchase health insurance until they needed care." 42 U.S.C.A. 18091(a)(2)(I). That practice would drive up premiums and threaten the viability of the individual insurance market. Accordingly, Congress found that the minimum coverage provision is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Ibid.* Congress also found that the minimum coverage provision "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for." 42 U.S.C.A. 18091(a)(2)(A). The uninsured as a class actively participate in the health care market, and Congress found that their "attempt to self-insure" leads to the consumption of health care for which they cannot pay and the imposition of those costs on other market participants. *Ibid.*; 42 U.S.C.A. 18091(a)(2)(F).

7. The Act makes a number of significant changes to Medicare, many of which are already in effect. For example, the Act changes Medicare payment rates and premiums, see, *e.g.*, 76 Fed. Reg. 21,432, 21,439-24,440 (Apr. 15, 2011) (summarizing some provisions). The Act's major Medicare reforms are expected to reduce costs by $507 billion between 2012 and 2021. Douglas W. Elmendorf, Director, CBO, *CBO's Analysis of the Major*

Health Care Legislation Enacted in March 2010: Prepared Statement for True Cost of PPACA: Effects on the Budget and Jobs: Hearing before the Subcomm. on Health of the House Comm. on Energy & Commerce, 111th Cong., 1st Sess. 25 (Mar. 30, 2011). And the Act will eliminate an anomaly (known as the "donut hole") in the prescription drug benefit under Medicare Part D, under which certain beneficiaries were required to pay all their prescription costs after meeting a certain threshold, until reaching a yearly out-of-pocket limit, when benefits resumed again. See 42 U.S.C. 1395w-102(b) (2006); HCERA § 1101, 124 Stat. 1036.

8. Many other provisions of the Act, only some of which are connected to health coverage, address other critical Congressional objectives, such as controlling costs, reducing waste and fraud, and improving public health. To name a few examples, the Act requires chain restaurants to disclose nutritional information about standard menu items, 21 U.S.C. 343(q)(5)(H); establishes a National Prevention, Health Promotion and Public Health Council, 42 U.S.C. 300u-10; amends the False Claims Act's "public disclosure" bar, see 31 U.S.C. 3730(e)(4); and reauthorizes the Indian Health Care Improvement Act, see ACA § 10221, 124 Stat. 935.

B. Proceedings Below

Petitioners are four individuals, the National Federation of Independent Business (NFIB), and 26 States.[7] They filed suit in the Northern District of Florida, challenging the constitutionality of several provisions of the Affordable Care Act.

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[7] The original individual petitioners are Mary Brown and Kaj Ahlburg. On January 17, 2012, the Court granted private petitioners' unopposed motion to add two new individuals (Dana Grimes and David Klemencic) as petitioners in this case and as respondents in 11-398.

1. The district court held that the minimum coverage provision is not a valid exercise of Congress's Article I powers, and further held that none of the other provisions of the Act are severable from the minimum coverage provision. Pet. App. 288a-367a. But recognizing that immediately halting implementation of the entire Act—many provisions of which were already in effect—"would be extremely disruptive and [would] cause significant uncertainty," the district court subsequently stayed its ruling. *Id.* at 389a; see *id.* at 387a-392a.

2. A divided court of appeals affirmed the district court's merits ruling but reversed on severability. In analyzing severability, the court of appeals did not address the federal government's contention that petitioners lack standing to challenge the vast majority of the Act's provisions as inseverable. See Gov't C.A. Br. 59-60 (citing *Printz* v. *United States*, 521 U.S. 898, 935 (1997)); Gov't C.A. Reply Br. 59.

The court of appeals rejected petitioners' argument that "wholesale invalidation" of the Act was required. Pet. App. 174a-176a. The court observed that "the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance." *Id.* at 174a. It noted that "such wholly unrelated provisions are too numerous to bear repeating," but cited several "representative examples." *Ibid.*

The court of appeals separately addressed the severability of the guaranteed-issue and community-rating provisions that all parties had agreed cannot be severed from the minimum coverage provision. Pet. App. 176a-186a. The court noted Congress's finding that the minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* at 177a (quoting 42 U.S.C.A. 18091(a)(2)(I)). It also recognized that the congressional "findings in that paragraph add that if there were no mandate, 'many individuals would wait to purchase health insurance until they needed care.'" *Ibid.* (quoting 42 U.S.C.A. 18091(a)(2)(I)). But concluding that these findings were irrelevant to the severability analysis, the court of appeals concluded that Congress would have enacted the guaranteed-issue and community-rating reforms without the minimum coverage provision because those insurance reforms "help consumers who need it the most," and therefore invalidated only the minimum coverage provision. *Id.* at 185a.

SUMMARY OF ARGUMENT

This case presents no occasion to consider issues of severability because the Affordable Care Act's minimum coverage provision is a constitutional exercise of Congress's Article I powers. If the Court concludes otherwise, however, it should reject petitioners' sweeping claims for relief. Petitioners' contention that the Court should invalidate the entire Act if the minimum coverage provision is found unconstitutional is not properly presented in this case and is meritless in any event.

1. Petitioners may not challenge the myriad provisions of the Act that do not apply to them. Parties must demonstrate standing for each form of relief they seek and, in doing so, cannot rely on the rights of third parties. This Court applied these principles in *Printz* v. *United States*, 521 U.S. 898 (1997). After invalidating a

portion of a statute as unconstitutional, the Court held there that it had "no business" addressing the alleged inseverability of additional provisions that did not "burden" the parties before the Court and that instead involved "the rights and obligations" of absent individuals. *Id.* at 935. The same analysis is called for here. The court of appeals therefore erred in addressing the severability of the myriad provisions that do not apply to petitioners, including the guaranteed-issue and community-rating provisions, because no entity regulated by those provisions is a party here. Applying these principles and certain statutory preclusions of review, if the Court accepts the individual petitioners' claim that the minimum coverage provision is unconstitutional, only the severability of the expansion of eligibility for Medicaid could properly be decided by the Court because the States are subject to that provision. The Court, however, would not be required to resolve that issue here.

2. If the Court nevertheless reaches the question, it should hold that only the guaranteed-issue and community-rating provisions of the Act are inseverable from the minimum coverage provision, and thus uphold the rest of the Act. When this Court identifies a constitutional defect in a portion of a statute, its normal rule requires partial, rather than total, invalidation, in order to respect the judgments of the democratically accountable Branches of government. After excising an unconstitutional provision, the Court therefore leaves in place remaining parts that are "consistent with Congress' basic objectives in enacting the statute" unless it is evident that Congress would not have wanted the remaining provisions to stand. *United States* v. *Booker*, 543 U.S. 220, 258-259, 265 (2005).

Congress in the Affordable Care Act used a number of tools to improve the functioning of the national market for health care by expanding the availability of coverage, regulating the terms on which insurance is offered, controlling costs, and rationalizing the timing and method of payment for health care services. For example, it expanded Medicaid eligibility (as it has done many times before); built on its historic practice of using the tax code to encourage health coverage by establishing tax credits for small businesses and individuals and by imposing taxes in certain circumstances on large employers that do not provide full-time employees adequate coverage; and adopted insurance market reforms (beyond guaranteed issue and community rating) similar to those enacted previously by States. Each of these provisions can operate independently of the minimum coverage provision and would advance Congress's goal of expanding affordable coverage if that provision were invalidated. Moreover, many provisions of the Act, focused on controlling costs, improving public health, and other objectives, have no connection to insurance coverage at all. And Congress directed that much of the Act take effect several years before the minimum coverage provision's effective date, further demonstrating that Congress intended those provisions to operate independently.

By contrast, the minimum coverage provision is essential to ensuring that the Act's 2014 guaranteed-issue and community-rating reforms advance Congress's goals. As Congress expressly found (and as experience in the States confirmed), those provisions would create an adverse selection cascade without a minimum coverage provision, because healthy individuals would defer obtaining insurance until they needed health care, leaving an insurance pool skewed toward the unhealthy. Premiums would increase significantly under that scenario, and the availability of insurance would decline—exactly the opposite of what Congress intended in enacting the Affordable Care Act. The guaranteed-issue and community-rating provisions are therefore inseverable from the minimum coverage provision.

ARGUMENT

Because the minimum coverage provision is a constitutional exercise of Congress's powers, this Court need not consider the issue of severability. If the Court does consider severability, however, it should reject petitioners' extraordinary claim that the entire Act be invalidated. Petitioners have identified no instance in which the modern Court has struck down the entirety of a comprehensive and multi-faceted Congressional enactment like this one based on a finding that one provision exceeds Congress's authority. Petitioners' arguments for doing so in this case are insubstantial, as the court of appeals correctly recognized. The vast majority of the provisions petitioners seek to invalidate do not apply to petitioners. Petitioners therefore do not have a cognizable interest to seek their invalidation on severability (or any other) ground.

In all events, petitioners have fallen far short of meeting their burden of demonstrating that Congress would not have wanted the bulk of the Act's provisions to operate independently of the minimum coverage provision. Many of those provisions are already in effect, several years in advance of the minimum coverage provision's effective date. And those and numerous other provisions advance the Act's core objectives of making affordable health care available to millions more Americans, controlling health care costs, and improving public health, irrespective of whether the minimum coverage provision becomes effective. The only provisions that would not advance Congress's goals (and could not function properly) absent a minimum coverage provision are the guaranteed-issue and community-rating provisions that take effect in 2014. As Congress's findings recognized, those provisions would create a serious adverse selection problem without a minimum coverage provision, producing higher costs and less insurance coverage. They are therefore inseverable.

I. THE SEVERABILITY OF MOST PROVISIONS OF THE ACT MAY NOT BE CONSIDERED IN THIS CASE

With the limited exception of state petitioners' argument concerning the Affordable Care Act's expansion of Medicaid eligibility, discussed below, petitioners' severability arguments are not properly presented in this case. Some sections of the Affordable Care Act provide for the assessment and collection of taxes, so pre-enforcement consideration of their validity (whether directly or as part of an inseverability claim) is barred by the Anti-Injunction Act.[8] Other portions of the Act re vise Medicare payment rates and are subject to exclusive administrative and judicial review provisions, which may be invoked only by persons who, unlike petitioners, are directly affected by those portions.[9] Petitioners cannot circumvent those procedures by seeking to invalidate the relevant sections of the Act here.

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[8] The Anti-Injunction Act, 26 U.S.C. 7421(a) (2006), provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." *Ibid.* A direct pre-enforcement constitutional challenge to one of the Affordable Care Act's sections providing for "the assessment or collection of any tax," *ibid.*, would be barred by the Anti-Injunction Act. So too is a challenge to one of those provisions in the form of an inseverability argument, because invalidation of a revenue provision on that basis likewise "would necessarily" prevent the federal government from assessing and collecting its attendant taxes. *Bob Jones Univ.* v. *Simon*, 416 U.S. 725, 731-732 (1974). Accordingly, the Anti-Injunction Act

In addition, and more generally, if the Court were to hold the minimum coverage provision unconstitutional, such a holding would furnish no basis for the Court to consider the continued validity of myriad other provisions of the Act that do not apply to petitioners. Whether viewed as a matter of Article III and prudential standing, a limitation on the scope of equitable relief, application of the principle that facial challenges are disfavored, or simply a matter of judicial restraint, the

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would bar the Court from reaching the question of the inseverability of the Affordable Care Act's many tax provisions, including the employer responsibility provision, 26 U.S.C. 4980H. See Gov't Cert.-Stage Br. 18-19 & n.9 (explaining why employer responsibility provision, but not minimum coverage provision, is covered by Anti-Injunction Act); see also, *e.g.*, 26 U.S.C. 1401(b)(2) (additional Medicare tax on high-income taxpayers); 26 U.S.C. 4980I (excise tax on high cost employer-sponsored health coverage); 26 U.S.C. 5000B (tax on indoor tanning services).

[9] Petitioners' attempt to challenge as inseverable from the minimum coverage provision the Act's provisions reducing spending on Medicare, see, *e.g.*, States' Br. 55, is barred by 42 U.S.C. 405(h) (2006) (as incorporated into the Medicare program by 42 U.S.C. 1395ii (2006)), which provides that "[n]o action against the United States, the Commissioner of Social Security, or any other officer or employee thereof shall be brought under [28 U.S.C. 1331 (2006) or 28 U.S.C. 1346 (2006 & Supp. IV 2010)] to recover on any claim arising under this subchapter." 42 U.S.C. 405(h) (2006); see *Shalala* v. *Illinois Council on Long Term Care*, 529 U.S. 1, 11, 14 (2000); *Weinberger* v. *Salfi*, 422 U.S. 749 (1975) (applying bar in Section 405(h) to constitutional challenge to statutory provision).

Court should not consider the validity of provisions of the Act that are not directed to petitioners but instead affect numerous parties not before the Court.

A. A plaintiff seeking to invalidate a federal statute must demonstrate, among other things, an injury in fact. See, *e.g.*, *Raines* v. *Byrd*, 521 U.S. 811, 818-820 (1997). A plaintiff must also satisfy established rules of prudential standing, such as the rule barring reliance on the rights of third parties. See, *e.g.*, *Warth* v. *Seldin*, 422 U.S. 490, 499 (1975). By limiting review to actual cases and controversies and limiting the ability of litigants to assert rights of third parties, these standing rules operate as an important check on using litigation as a forum for airing mere policy or political disagreements. See, *e.g.*, *Arizona Christian Sch. Tuition Org.* v. *Winn*, 131 S. Ct. 1436, 1441-1442, 1449 (2011). There is no basis in this Court's precedents for disregarding those rules simply because a party seeks to invalidate a statutory provision as inseverable from a constitutionally defective provision, rather than as unconstitutional in itself.

This Court has repeatedly held that "[s]tanding is not dispensed in gross." *Davis* v. *Federal Election Comm'n*, 554 U.S. 724, 734 (2008) (quoting *Lewis* v. *Casey*, 518 U.S. 343, 358 n.6 (1996)). "Rather, 'a plaintiff must demonstrate standing for each claim he seeks to press' and 'for each form of relief' that is sought." *Ibid.* (quoting *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 352 (2006)). That rule fully applies when the relief sought is invalidation of a provision of a federal law as inseverable.

In *Printz* v. *United States*, 521 U.S. 898 (1997), the Court rejected a request that it decide the severability of provisions of the Brady Handgun Violence Prevention

Act (Brady Act), Pub. L. No. 103-159, 107 Stat. 1536, that did not burden the parties to the litigation. The Court held that the provisions requiring local law enforcement officers to conduct background checks of prospective gun buyers unconstitutionally commandeered those officers. *Printz*, 521 U.S. at 904-933. The law enforcement officers did not challenge the constitutionality of the separate provisions requiring firearms dealers to notify law enforcement officers of proposed firearms purchases and to wait five days before completing the sale. They did, however, argue that those provisions were inseverable from the invalid background-check requirement. See *id.* at 935.

The Court concluded that it had "no business" addressing severability because the waiting-period provisions "burden only firearms dealers and purchasers, and no plaintiff in either of those categories is before us here." *Printz*, 521 U.S. at 935. The Court declined "to speculate regarding the rights and obligations of parties not before the Court," and on that basis it distinguished *New York* v. *United States*, 505 U.S. 144, 186-187 (1992), which had "address[ed] severability where [the allegedly inseverable provisions] affected the plaintiffs." *Printz*, 521 U.S. at 935. *Printz* thereby gave effect to the established principle that "third parties themselves usually will be the best proponents of their own rights. The courts depend on effective advocacy, and therefore should prefer to construe legal rights only when the most effective advocates of those rights are before them." *Singleton* v. *Wulff*, 428 U.S. 106, 114 (1976) (plurality opinion).

As *Printz* demonstrates, there is no inseverability exception to the rule against adjudicating claims involving only the rights of third parties. "At bottom, 'the gist of the question of standing' is whether petitioners have 'such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues upon which the court so largely depends for illumination.'" *Massachusetts* v. *EPA*, 549 U.S. 497, 517 (2007) (quoting *Baker* v. *Carr*, 369 U.S. 186, 204 (1962)); see *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 581 (1992) (Kennedy, J., concurring in part and concurring in the judgment) (Standing requirements ensure that "the legal questions presented . . . will be resolved, not in the rarified atmosphere of a debating society, but in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action.") (quoting *Valley Forge Christian Coll.* v. *Americans United for Separation of Church & State, Inc.*, 454 U.S. 464, 472 (1982)). The need for concrete adverseness, by parties whose rights are directly affected, is no less necessary in the context of severability than in any other.

The absence of a properly adversarial presentation infects petitioners' severability argument at every turn. For example, private petitioners argue that a number of insurance reforms beyond guaranteed issue and community rating are inseverable on the ground that those additional reforms would "forc[e] insurers to offer policies on economically unfavorable terms" and, absent a minimum coverage provision, would unfairly "burden[] * * * insurance companies." NFIB Br. 41. Yet the insurance industry itself, which appears as an amicus and is able to identify any unfair burden on insurers and advance the industry's own interests, does *not* argue that any provisions (other than guaranteed-issue and community-rating) are inseverable. See America's Health Ins. Plans Amicus Br. 11-39 (AHIP Amicus Br).

Likewise, petitioners seek to invalidate the Act's tax credits for purchase of health insurance. *E.g.*, NFIB Br. 49; States Br. 45. Nowhere have they explained why they desire—much less established anything approaching a judicially cognizable stake in—invalidation of tax benefits directed to millions of individuals not before the Court. As this Court has observed, a rule permitting parties to challenge the validity of tax credits made available to others would "cast[] the Court in the role of a Council of Revision, conferring on itself the power to invalidate laws at the behest of anyone who disagrees with them." *Arizona Christian Sch. Tuition Org.*, 131 S. Ct. at 1443, 1449.

B. 1. Even assuming that NFIB has standing to represent its members in this case at all (but see Gov't Minimum Coverage Br. 16 n.5), NFIB has made no effort to establish representational standing to advance any interests of its members in invalidating the tax credits or any other provision aside from minimum coverage. To the contrary, NFIB's attack on the Act's tax credits would necessarily invalidate the credits for eligible small businesses that offer health insurance coverage to their employees, 26 U.S.C. 45R, a consequence that presumably would *disadvantage* the NFIB members eligible for such credits. Nor have the individual petitioners made any effort to establish their standing to challenge that or any other provision beyond minimum coverage. Although the federal government raised its standing objection at the certiorari stage, see Gov't Cert.-Stage Br. 29, as it had in the court of appeals, private petitioners ignore the issue.

2. State petitioners, for their part, argue that they do not have to demonstrate that the Act's other provisions burden them because severability is a "*remedial*

doctrine." States' Br. 27. But "remedial" action by an Article III court is taken only when necessary to remedy an injury to a party before the court. State petitioners have no cognizable claim to a remedy with respect to statutory provisions that do not apply to them.

Indeed, state petitioners are particularly ill-positioned to argue that a wide-ranging inquiry into the inseverability of any other provisions of the Act is a suitable "remedy" for the asserted unconstitutionality of the minimum coverage provision. Because that provision does not even apply to them, state petitioners lack standing to challenge it, see Gov't 11-398 Cert.-Stage Reply Br. 9-11, much less to seek invalidation of *other* provisions of the Act as a "remedy" for the invalidity of the minimum coverage provision. Affording them such a remedy would cast aside the established principle that a plaintiff "must demonstrate standing * * * for each form of relief that is sought." *Davis*, 554 U.S. at 734 (internal quotation marks and citations omitted).[10]

State petitioners hypothesize that "*Printz* may reflect nothing more than the unremarkable proposition that courts will not 'speculate' concerning issues that have not been fully developed at each stage of the litigation." States' Br. 31. That is incorrect. The Court in *Printz* stressed that the question of severability had in fact been "briefed and argued" and noted that it had been decided by the district court. 521 U.S. at 904, 935. The Court nonetheless held that it had "no business answering" the severability question, expressly noting that the allegedly inseverable provisions "burden only firearms dealers and purchasers, and no plaintiff in either of those categories is before us here." *Id.* at 935.

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[10] Decisions on which state petitioners rely (States' Br. 27-29) are inapposite because they considered the severability of provisions that did burden parties before the Court. See, *e.g.*, *United States* v. *Booker*, 543 U.S. 220, 246, 259 (2005); *New York*, 505 U.S. at 186; *Alaska Airlines, Inc.* v. *Brock*, 480 U.S. 678, 692-697 (1987); *Champlin Ref. Co.* v. *Corporation Comm'n*, 286 U.S. 210, 223 n.*, 234 (1932); cf. *Pollock* v. *Farmers' Loan & Trust Co.*, 158 U.S. 601, 604, 635-637 (1895); see also *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 324, 331 (2006) (addressing severability of specific applications of parental-notice provisions challenged by abortion providers).

State petitioners contend that, unless this Court now addresses their assertion that every other provision of the Act is inseverable from the minimum coverage provision, no other party would have the opportunity to raise inseverability. See States' Br. 33-34. Petitioners are mistaken.[11] This Court in *Printz* took as a given that firearms dealers and purchasers would be able to challenge the Brady Act's waiting period provisions as inseverable from the unconstitutional background check provision. See 521 U.S. at 935; see also *Frank* v. *United States*, 129 F.3d 273, 275-276 (2d Cir. 1997) (per curiam) (recognizing, post-*Printz*, that challenge to waiting period as inseverable could be "considered" when "the proper parties [were] before this Court"). Similarly, the continued validity of the myriad provisions of the Affordable Care Act that do not apply to petitioners can be challenged (at the appropriate time and in the appropriate way) by others to whom they do apply. Medicare providers and taxpayers, for example, have established mechanisms for raising such challenges (see notes 8 and 9, *supra*), and others may have a cause of action under the Administrative Procedure Act, 5 U.S.C. 701 *et seq.*, or on some other basis, or could assert any non-severability argument as a defense in enforcement or other proceedings.

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[11] This Court has consistently rejected the proposition that a party before the Court should be found to have standing simply because otherwise no party could sue. See, *e.g.*, *Schlesinger* v. *Reservists Comm. to Stop the War*, 418 U.S. 208, 227 (1974).

With respect in particular to the guaranteed-issue and community-rating provisions that take effect in 2014, the United States is on record conceding their inseverability. That position presumably would itself have a significant impact on any future efforts to enforce or invoke those provisions in the event the Court invalidated the minimum coverage provision. If issues nevertheless did arise, they could be raised in a suitable action by a proper party. State petitioners, however, are not such parties.

Finally, state petitioners' attempt to circumvent normal standing rules is not helped by their observation that severability analysis is designed to further congressional intent. *E.g.*, States' Br. 28. For the Court to engage in a wide-ranging severability inquiry, untethered to any need to afford a remedy to parties before the Court and instead for the supposed benefit of Congress, would be to render an advisory opinion. *All* questions of statutory interpretation ultimately turn on congressional intent. That truism does not relieve the courts of their obligation to ensure the presence of a party with standing before they attempt to discern what that intent was. See *DaimlerChrysler*, 547 U.S. at 341. As this Court has emphasized, "[t]he federal courts have abjured appeals to their authority which would convert the judicial process into 'no more than a vehicle for the vindication of the value interests of concerned bystanders.'" *Valley Forge Christian Coll.*, 454 U.S. at 473 (citation omitted). Petitioners' severability arguments present precisely that risk.

C. Other principles reinforce the conclusion that the Court should not entertain petitioners' arguments against the continued validity of provisions of the Act that do not apply to them or that they have not established standing to challenge. Most fundamentally, because judging the constitutionality of an Act of Congress is "the gravest and most delicate duty that this Court is called upon to perform," *Rostker* v. *Goldberg*, 453 U.S. 57, 64 (1981) (quoting *Blodgett* v. *Holden*, 275 U.S. 142, 148 (1927) (Holmes, J.)), the Court should proceed with great caution and address the continued validity of provisions other than the one found unconstitutional only when necessary to the disposition of a concrete case before it. Moreover, as relevant here, petitioners brought this suit to seek declaratory and injunctive relief based on the asserted unconstitutionality of the minimum coverage provision. It is well established that an equitable remedy should extend no further than what is necessary to afford relief for an adjudicated violation based on the plaintiff's claim.[12] Finally, petitioners' request that the Court strike down the entire Act is a facial challenge to the entire Act. This Court has made clear that facial challenges are disfavored and that a court should tailor its analysis and resulting remedy to the application of the statute specifically challenged. See *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 328-331 (2006); *Sabri* v. *United States*, 541 U.S. 600, 608-610 (2004).

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[12] See, *e.g.*, *Monsanto Co.* v. *Geertson Seed Farms*, 130 S. Ct. 2743, 2760 (2010) (narrowing injunction in part because plaintiffs "do not represent a class, so they could not seek to enjoin such an order on the ground that it might cause harm to other parties"); *Doran* v. *Salem Inn, Inc.*, 422 U.S. 922, 931 (1975) (noting that "neither declaratory nor injunctive relief can directly interfere with enforcement of contested statutes or ordinances except with respect to the particular federal plaintiffs"); see also *United States Dep't of Def.* v. *Meinhold*, 510 U.S. 939 (1993).

D. 1. Because no entity regulated by the guaranteed-issue and community-rating provisions is a party in this case, the court of appeals erred in addressing whether those provisions are severable from the minimum coverage provision. Accordingly, in the event the Court invalidates the minimum coverage provision, it should vacate the portion of the lower court's judgment finding those two provisions severable.

2. This case likewise does not present an appropriate vehicle to consider petitioners' broadside challenge to the myriad other provisions of the Affordable Care Act. Private petitioners presented no evidentiary basis below to establish any cognizable interest in invalidating any provision of the Act other than the minimum coverage provision, nor have they contended that they have independent standing to do so.

The situation is largely the same for state petitioners. If the Court first agrees with the constitutional challenge to the minimum coverage provision advanced by the individual petitioners with standing to bring that challenge, state petitioners, as large employers, would then have standing to challenge the Act's employer-responsibility provision as inseverable, Medicaid J.A. 96-100,[13] although the Anti-Injunction Act would pose an independent bar to that pre-enforcement challenge, see note 8, *supra*. Likewise, if the Court first holds the minimum coverage provision unconstitutional, state petitioners then would have standing to challenge the Act's expansion of Medicaid eligibility as inseverable from the minimum coverage provision. See Medicaid J.A. 70-82. But the Court would not be required to reach or decide that issue here. Resolution of that severability issue concerning Medicaid is not necessary to afford relief to the individual petitioners who have standing to challenge the minimum coverage provision, because they do not claim to be adversely affected by the Medicaid eligibility provisions. And state petitioners cannot insist as a matter of right that the Court resolve that severability issue as a remedy for them in this case, because the minimum coverage provision—even if unconstitutional as to individual petitioners—violates no rights of state petitioners that might in turn form a basis for affording them a remedy in this case. Accordingly, if the Court holds the minimum coverage provision unconstitutional, it could decline to resolve the Medicaid severability issue at this time or in this case as a matter of prudence and judicial restraint.

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[13] Medicaid J.A. refers to the joint appendix filed in No. 11-400.

State petitioners have not asserted any basis for standing to seek invalidation of any of the Act's other provisions. For example, although state petitioners urged in district court that they were burdened by the Act's exchange provisions, the court rejected that challenge because state participation in the exchanges is voluntary. See Pet. App. 452a. State petitioners did not appeal that ruling, and they do not argue that they are burdened by the provisions that give them the option to establish exchanges. Accordingly, the Court should not consider the severability of those provisions or any remaining provisions of the Act.

II. IF THE COURT REACHES THE QUESTION, IT SHOULD HOLD THAT THE ACT IS SEVERABLE FROM THE MINIMUM COVERAGE PROVISION EXCEPT FOR THE GUARANTEED-ISSUE AND COMMUNITY-RATING PROVISIONS THAT TAKE EFFECT IN 2014

The minimum coverage provision is key to one component of a comprehensive program of economic regulation and incentives to expand access to affordable health care. See Gov't Minimum Coverage Br. 24-32. And all parties agree that the minimum coverage provision is necessary to make effective the Act's guaranteed-issue and community-rating insurance market reforms. See *Id.* at 28-30; States' Br. 12, 47; NFIB Br. 36-40. Accordingly, the Court should affirm the constitutionality of the minimum coverage provision, see Gov't Minimum Coverage Br. 24-32, rendering it unnecessary to decide any question of severability.

In the event, however, that the Court does have occasion to address severability (but see pp. 14-25, *supra*), the place of the minimum coverage provision in the larger statutory context would again be relevant. In particular, without a minimum coverage provision, the guaranteed-issue and community-rating provisions would drive up costs and reduce coverage, the opposite of Congress's goals. They are therefore inseverable from the minimum coverage provision and must be invalidated if the Court finds it unconstitutional. See Point II.C., *infra*.

But those are the only provisions of the Act in that category. Other provisions can operate independently and would still advance Congress's core goals of expanding coverage, improving public health, and controlling costs even if the minimum coverage provision were held unconstitutional. Petitioners fail to meet their burden of demonstrating that the Congress that enacted the Affordable Care Act would have wanted all of those provisions to fall with the minimum coverage provision, not to mention the many provisions that have nothing to do with health coverage.

A. The Court Invalidates As Inseverable No More Of A Statute Than Is Strictly Necessary

This Court has repeatedly held that, "when confronting a constitutional flaw in a statute," a court must "try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact." *Free Enter. Fund* v. *Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (internal quotation marks and citation omitted); see *Ayotte*, 546 U.S. at 329 ("[W]e try not to nullify more of a legislature's work than is necessary, for we know that '[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people.'") (second brackets in original) (quoting *Regan* v. *Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion)). "[T]he 'normal rule,'" therefore, "is that 'partial, rather than facial, invalidation is the required course' such that a 'statute may . . . be declared invalid to the extent that it reaches too far, but otherwise left intact.'" *Ibid.* (citation omitted).

Accordingly, when this Court invalidates a portion of a statute, it "must retain those portions of the Act that are (1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." *United States* v. *Booker*, 543 U.S. 220, 258-259 (2005) (internal quotation marks and citations omitted); see *id.* at 263 (in deciding severability, court must ask "which alternative adheres more closely to Congress' original objective"); *Time, Inc.*, 468 U.S. at 653 (plurality opinion) (relevant question whether "the policies Congress sought to advance by enacting [the invalidated provision] can be effectuated even though [the provision] is unenforceable"). To invalidate provisions as inseverable under these standards, a party bears the burden of demonstrating that it is "*evident*" that the Congress that enacted the invalid provision "would have preferred" that those additional provisions be invalidated as well. *Free Enter. Fund*, 130 S. Ct. at 3162 (emphasis added; citation omitted); see *Ayotte*, 546 U.S. at 330 ("Would the legislature have preferred what is left of its statute to no statute at all?"); *Booker*, 543 U.S. at 265 (Court must determine Congress's "likely intent *in light of*" the Court's constitutional holding).

B. Petitioners Fail To Demonstrate That It Is "Evident" Congress Would Have Wanted The Entire Act To Fall If The Minimum Coverage Provision Were Invalidated

Petitioners contend that, if the minimum coverage provision is invalidated, the entire Affordable Care Act must fall. As the court of appeals recognized, that contention is meritless. "[T]he lion's share of the Act has nothing to do with private insurance," Pet. App. 174a, and many of its provisions have already gone into effect, years before the minimum coverage provision. Petitioners have not come close to showing that it is evident that Congress would have wanted to undo every single one of the Act's myriad provisions—thereby denying affordable health care to millions of Americans and forgoing hundreds of billions of dollars in cost savings—if that one section were held unconstitutional.

1. Petitioners' argument for complete invalidation fails at the outset because of a fundamental feature of the Act they ignore: Many of its provisions are already in effect, several years before the minimum coverage provision becomes effective in 2014. See, *e.g.*, pp. 4-5, *supra*; see generally Kaiser Family Found., *Health Reform Source: Implementation Timeline*, http://healthreform.kff.org/Timeline.aspx (last visited Jan. 26, 2012). That time lag establishes conclusively that much of the Act operates independently of the minimum coverage provision. One need not speculate whether Congress would have wanted such provisions to operate in a world without the minimum coverage provision. We are in that world now.

Given that many provisions of the Act are now in operation, Congress cannot possibly have intended the extraordinary disruption that a finding of total inseverability would cause in the event a provision not taking effect until 2014 were invalidated. For example, more than 20 sections of the Act made changes to Medicare payment rates for calendar or fiscal years beginning in 2011, see, *e.g.*, 42 U.S.C. 1395w-4(e)(1)(H), and these changes have been implemented through notice-and-comment rulemaking, see, *e.g.*, 75 Fed. Reg. 73,170 (Nov. 29, 2010) (adjusting Medicare physician fee schedule for calendar year 2011, consistent with ACA provisions); 76 Fed. Reg. 73,026 (Nov. 28, 2011) (same for 2012). The Act's Medicare provisions have thus already formed the basis for millions of payments to providers for the benefit of individual beneficiaries. It is not remotely evident that Congress would have intended those provisions to fall (raising the prospect of unwinding countless transactions) in the event a wholly unrelated provision were invalidated.

A ruling of total inseverability would also create other bizarre results. For example, several portions of the Act extended certain pre-existing Medicare payment provisions, such as one involving air ambulance services. See ACA § 3105(b), 124 Stat. 417; ACA § 10311(b), 124 Stat. 943. Congress subsequently extended this provision. See Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, § 106(b), 124 Stat. 3287 (extending provision through 2011); Temporary Payroll Tax Cut Continuation Act of 2011, Pub. L. No. 112-78, § 306(b), 125 Stat. 1285 (extending provision through first two months of 2012). According to petitioners, therefore, Congress intended, in the event the minimum coverage provision were invalidated, for such Medicare payment provisions to be deemed to have lapsed for a year (2010) on inseverability grounds, before springing back to life when later extended through non-invalidated legislation.

Petitioners' total-invalidation argument is similarly irreconcilable with myriad other Affordable Care Act provisions "wholly unrelated" to the minimum coverage provision. Pet. App. 174a (providing examples); see pp. 7-8, *supra*; see also Pet. App. 352a-353a (district court examples). Among those unrelated provisions are those that: "provide[] for more rigorous enforcement" of drug-pricing requirements, *Astra USA, Inc.* v. *Santa Clara Cnty.*, 131 S. Ct. 1342, 1346 (2011); reauthorize various federal programs that were already on the books, *e.g.*, ACA § 4204(c), 124 Stat. 572 (reauthorizing immunization program), § 5603, 124 Stat. 679 (reauthorizating Wakefield Emergency Medical Services for Children Program); and amend the False Claims Act's "public disclosure bar," *Schindler Elevator Corp.* v. *United States ex rel. Kirk*, 131 S. Ct. 1885, 1889 n.1 (2011). Indeed, petitioner Washington State conceded below that the Act's reauthorization of the Indian Health Care Improvement Act, 25 U.S.C. 1601 *et seq.*, could be severed from the minimum coverage provision. See States' C.A. Br. 65 n.8. These provisions "have a stand-alone quality and are 'fully operative as a law.'" *West Va. CWP Fund* v. *Stacy*, No. 11-1020, 2011 WL 6062116, at *3 n.2 (4th Cir. Dec. 7, 2011) (Wilkinson, J.) (holding that ACA's amendment to Black Lung Benefits Act, 30 U.S.C. 901 *et seq.*, regarding standard for receiving survivor benefits is severable from minimum coverage provision).[14]

Petitioners cavalierly dismiss such provisions as "various obscure measures that appear independent of [the Act's] major planks," and contend that they should simply be swept away because it would be too difficult to determine whether they are severable. NFIB Br. 54-56. But petitioners make no attempt to explain *why* any such provisions *are* inseverable, thereby effectively conceding that it actually is not difficult at all to find them severable.

In any event, petitioners have their presumptions backwards. Because petitioners bear the burden of demonstrating that it is evident Congress would have wanted these provisions and numerous others to fall in the event the minimum coverage provision were invalidated, ***Free Enter. Fund***, 130 S. Ct. at 3162, any uncertainty must be resolved in favor of leaving the legislation intact. Congress, not the Court, is in the best position to make any necessary adjustments. *Booker*, 543 U.S. at 265.

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[14] Many other provisions of the Act have been applied by the courts, further demonstrating how Congress's decision to make them immediately effective has embedded them in the fabric of the law. See, *e.g.*, *Henry Ford Health Sys.* v. *HHS*, 654 F.3d 660 (6th Cir. 2011) (Secretary reasonably exercised authority under ACA in promulgating regulation addressing Medicare reimbursements costs); *United States* v. *Mateos*, 623 F.3d 1350, 1368 (11th Cir. 2010) (O'Connor, J.) (holding that an above-Sentencing Guidelines sentence for health care fraud was reasonable, relying in part on ACA provision directing Sentencing Commission to amend Guidelines to ensure that health care fraud is punished more severely), cert. denied, 131 S. Ct. 1540 (2011).

Petitioners' total-invalidation argument, in short, is groundless. And other than stressing the inseverability of the guaranteed-issue and community-rating reforms from the minimum coverage provision—a position with which the federal government agrees, see Point II.C., *infra*—petitioners eschew any further "provision-by-provision" inseverability claim. NFIB Br. 55; see States' Br. 52 (declining to "examin[e] in isolation particular relationships between discrete components"). Accordingly, if the Court were to invalidate the minimum coverage provision and conclude there is no barrier to resolving the severability of that provision from the guaranteed-issue and community-rating provisions that take effect in 2014, it should declare only those provisions inseverable and allow the rest of the Act to stand.

2. To the extent, however, that the Court addresses any additional provisions of the Act, it should find them severable from the minimum coverage provision. State petitioners attempt to support their inseverability argument by erroneously framing the Affordable Care Act as nothing more than an attempt to "ensure an adequate supply to meet the artificial demand forcibly created by the individual mandate." States' Br. 35. With the minimum coverage provision in the "demand" category, they then attempt to shoe-horn every other provision of the Act into either the "supply" category or a third category of "cost-savings provisions designed to counterbalance the expensive supply-side provisions." *Ibid.* If the "de-

mand" provision falls, the argument continues, then the supply and financing provisions should as well. *Ibid.*

Although that construct serves petitioners' rhetorical purposes, it bears no relation to what Congress was actually doing when it enacted the Affordable Care Act. The Act was not an abstract exercise in stimulating "artificial demand" for health insurance and then matching it with a given level of supply in order to achieve some ideal equilibrium. Quite the opposite. Congress's overriding goal of the Act was to expand affordable coverage for real human beings in the real world so that they could obtain needed health care. Congress found that a core impediment to coverage was discriminatory practices by private insurers, which shut millions of people who wanted health insurance out of the market. It decided to end those practices, and, in order to make that market reform possible, it adopted the minimum coverage provision. In so doing, Congress also rationalized payment for services consumed by the uninsured in the health care market, and thereby dealt with the economic dislocation resulting from the massive cost-shifting that characterized that market. But the Act also includes a variety of other provisions (such as premium tax credits and exchanges) that lower barriers to obtaining health coverage and extend coverage to those who otherwise would not be able to afford it. It is fanciful to suggest that those numerous other provisions are "mere adjuncts," *Williams* v. *Standard Oil Co.*, 278 U.S. 235, 243 (1929), to the minimum coverage provision designed to prop up the supply of available insurance. Each is a stand-alone provision that independently advances in distinct ways Congress's core goal of expanded affordable coverage.

The fact that those other provisions substantially advance the same basic objective as the minimum coverage provision surely does not render them inseverable. Again, the opposite is true: With or without the minimum coverage provision, each would independently remain "consistent with Congress' basic objectives in enacting the statute," *Booker*, 543 U.S. at 258-259, and would continue to further "Congress' basic statutory goal," *id.* at 250. Accordingly, invalidation of the minimum coverage provision "does not require the *total* frustration of Congress' basic purpose," *United States* v. *Jackson*, 390 U.S. 570, 591 (1968) (emphasis added), through invalidation of those other provisions as well. "Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated." *New York*, 505 U.S. at 186. Indeed, a Congress that deployed multiple tools comprehensively to advance its goals would have been all the more committed to those remaining in the event one provision were invalidated.

a. Among the tools Congress used to expand access to health care was the expansion of eligibility for Medicaid. See NFIB Br. 52. This expansion was only the latest in a series since Medicaid's inception in 1965, see p. 3, *supra*, and none of the others was accompanied by a minimum coverage provision. Petitioners fail entirely to demonstrate that it is evident that Congress would have viewed this expansion (alone among all the ones it has initiated in the last four decades) as inextricably tied to such a provision. Nor do petitioners suggest why Congress would have wanted to forgo extending coverage to millions of previously uninsured Americans, merely because it could not achieve the additional benefits of the minimum coverage provision.

b. Similarly, petitioners fail to demonstrate that it is evident Congress would have wanted the employer responsibility provision, 26 U.S.C. 4980H, to fall if the minimum coverage provision were invalidated. See NFIB Br. 51. This provision is just the latest example of Congress's use of the tax code to encourage employers to provide their employees with affordable health coverage. See pp. 2-3, *supra*. Many past health care reform proposals were based on such employer provisions and did not include a minimum coverage provision. See Gov't Minimum Coverage Br. 13-14. Indeed, for more than 37 years, Hawaii has had an employer responsibility provision without a minimum coverage provision. See Thomas C. Buchmueller et al., *The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Evidence from Hawaii*, Am. Econ. J. Econ. Pol'y, Nov. 2011, at 25, 25-26. Congress is well aware of Hawaii's statute, as it enacted a special provision to save it from preemption under ERISA. See 29 U.S.C. 1144(b)(5) (2006); see also ACA § 1560(b), 124 Stat. 262 (relevant portion of ACA shall not be "construed to modify or limit the application" of Hawaii's ERISA exemption). To be sure, the minimum coverage provision complements the employer responsibility provision (as well as other provisions, both pre-existing and in the Affordable Care Act) by encouraging employees to seek and accept employer-based coverage. See Gov't Minimum Coverage Br. 32. But a mere "relationship" between provisions does not render them inseverable. *Buckley* v. *Valeo*, 424 U.S. 1, 108 (1976) (per curiam).

c. Petitioners have also failed to show that the Act's premium tax credits, 26 U.S.C. 36B, are inseverable from the minimum coverage provision. Cf. NFIB Br. 49-50. Contrary to private petitioners' speculation, the federal government's costs in providing those tax credits would not "skyrocket" if the minimum coverage provision were invalidated. *Id.* at 49. To the contrary, the expense would fall substantially because fewer people would obtain coverage and thus claim the credits. See *CBO's June 2010 Analysis* 2 (exchange subsidies would be $39 billion less without minimum coverage provision); Matthew Buettgens et al., *Why the Individual Mandate Matters* 5 (2010) (Tbl. 2) (government's total outlay for premium tax credits would fall more than 30% without minimum coverage provision). In any event, Congress included two provisions (including a "failsafe" based on a specified share of gross domestic product) that limit the impact of premium growth on the government's total tax credit expenditures. See 26 U.S.C. 36B(b)(3)(A)(ii).[15]

d. The Act's health insurance exchange provisions, 42 U.S.C.A. 18031-18044, are also severable from the minimum coverage provision. Cf. NFIB Br. 51-52.

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[15] While the premium tax credit provision uses premium costs (of the second lowest "silver" plan) in a "rating area" as a basis for calculation, 26 U.S.C. 36B(b)(3)(C); see NFIB Br. 50, the Act's "rating area" provision, 42 U.S.C. 300gg(a)(2), is distinct from the community-rating provision, 42 U.S.C. 300gg(a)(1), and is thus severable from it. See note 23, *infra*. Similarly, the provision establishing the actuarial value requirements for a "silver" plan, 42 U.S.C.A. 18022(d), is independent of community rating. In the absence of community rating, plan premiums could vary based not only on the ages of different household members, the rating area where they reside, and the composition of the household, but also on other factors, including health factors. The premium for the second lowest cost silver plan would be identified in accordance with 26 U.S.C. 36B(b)(3)(C).

While the exchanges would not promote competition and lower costs as effectively without guaranteed-issue and community-rating rules, see Gov't Minimum Coverage Br. 31, they would still operate as "organized and transparent marketplace[s] for the purchase of health insurance where individuals and employers * * * can shop and compare health insurance options." H.R. Rep. No. 443, 111th Cong., 2d Sess. Pt. 3, at 976 (2010) (internal quotation marks and footnote omitted). CBO has estimated that "organiz[ing] purchasers into larger groups" through mechanisms like exchanges could, by itself, lower average policy premiums by three percent. *Key Issues* 71. Indeed, although petitioner Utah has no minimum coverage provision (or guaranteed issue or community rating), it established the "Utah Health Exchange" in 2009 to "serve as a single shopping point allowing consumers to evaluate their health insurance options and execute informed purchasing decisions." Press Release, Utah Governor's Office of Econ. Dev., *Governor's Office of Economic Development to launch the Utah Health Exchange* 1 (Aug. 19, 2009); see State Health Access Data Assistance Ctr., *Issue Brief No. 23, Health Insurance Exchanges: Implementation and Data Considerations for States and Existing Models for Comparison* (2010) (discussing pre-ACA exchanges in Utah, Connecticut, Washington, and Massachusetts).[16]

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[16] Several state petitioners have recognized that exchanges would be beneficial even without a minimum coverage provision. See, *e.g.*, Letter from Haley Barbour, Governor of Mississippi, to HHS Secretary Kathleen Sebelius (June 29, 2011) ("I have supported establishing an insurance exchange targeting small businesses since 2008."), attached to Mississippi's *Application for Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges* (June 29, 2011); Colorado Health Benefit Exch., *FAQs*, http://www.

e. Private petitioners make a cursory argument that some of the Act's insurance reforms, beyond guaranteed issue and community rating, are also inseverable from the minimum coverage provision on the ground that, absent that provision, those additional reforms would unfairly burden the insurance industry. See NFIB Br. 40-41; see also Chamber of Commerce Amicus Br. 23-31. As noted above, however, the insurance industry itself does not claim any such burden (and does not contend those additional reforms are inseverable), see p. 18, *supra*, refuting private petitioners' argument. Moreover, Congress directed that many of those additional reforms take effect well in advance of the minimum coverage provision, demonstrating that it intended them to operate separately from that provision. See pp. 4-5, 29, *supra*.

Private petitioners' cursory argument fares no better when those insurance reforms are considered individually. First, there is no reason to believe that a Congress concerned about the cost of health insurance would have wanted the provision authorizing "review" of "unreasonable increases in premiums for health insurance coverage," 42 U.S.C. 300gg-94; see NFIB Br. 11, to fall if the minimum coverage provision were invalidated.

Second, there is no valid case for the inseverability of the requirement that insurers offer a minimum level of "essential health benefits." 42 U.S.C. 300gg-6(a); see NFIB Br. 11, 40. Congress has previously enacted such requirements without a minimum coverage provision, see, *e.g.*, 42 U.S.C. 300gg-4, 300gg-51 (2006) (specified

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getcoveredco.org/FAQs (last visited Jan. 25, 2012) ("Regardless of how these cases [challenging the minimum coverage provision] end, Colorado has chosen to move forward with its own health insurance exchange.").

maternity benefits), and every State has enacted similar rules, see Council for Affordable Health Ins., *Health Insurance Mandates in the States 2010*, at 11-34 (2010).[17]

Third, both federal and state laws have previously placed "limits [on] cost-sharing" (NFIB Br. 40) without a minimum coverage provision. See, *e.g.*, 42 U.S.C. 300e(b)(1) (2006) (health maintenance organizations may require members to make only "nominal payments" for basic health services beyond periodic premiums); Cal. Health & Safety Code § 1373.4 (West 2008) (limiting copayments and deductibles for maternity services).

Fourth, the prohibition on rescinding coverage absent fraud or intentional misrepresentation by a policyholder, 42 U.S.C. 300gg-12; see NFIB Br. 11, 40, is a basic consumer protection measure,[18] mirroring those enacted by States without a minimum coverage provision, see, *e.g.*, N.M. Stat. § 59A-23E-14 (2000); *id.* § 59A-23E-19.

Fifth, there is no reason to believe Congress would have wanted the Act's prohibition on insurers' setting artificial dollar "limits on coverage" (NFIB Br. 40) to fall without a minimum coverage provision. Congress directed that those reforms take effect several years before that provision and, even before passage of the Act (and thus in a market without a minimum coverage provision), annual dollar limits on coverage were not common. See HHS, ***Fact Sheet: The Affordable Care Act's New Patient's Bill of Rights*** (June 22, 2010) (92% of larger employer plans, 86% of small employer plans, and 81% of individual plans include no annual limits).

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[17] Moreover, HHS has announced that it intends to define essential health benefits based on a benchmark plan selected by each State itself. Center for Consumer Info. & Ins. Oversight, HHS, *Essential Health Benefits Bulletin* 8 (Dec. 16, 2011).

[18] See 75 Fed. Reg. 37,208 (June 28, 2010) (noting that Congress adopted this rule in response to "questionable practices in this area including insurance companies rescinding coverage even when discrepancies are unintentional or caused by others, for conditions that are unknown to policyholders, and for discrepancies unrelated to the medical conditions for which patients sought medical care").

Finally, there is no merit to the argument of amicus Chamber of Commerce that the Act's provisions on medical loss ratios (requiring that insurers spend a certain percentage of premium revenue on certain benefits) and risk-adjustment (requiring payments among insurers based on actuarial risk of their insured populations) are inseverable. See Chamber Amicus Br. 25-27, 29-31. These are familiar insurance regulatory tools used in a variety of settings without a minimum coverage provision. See, *e.g.*, 42 U.S.C. 1395w-23(a)(1)(C) (2006) (risk adjustment provision for Medicare managed care organizations); Ross Winkelman & Rob Damler, ***Risk Adjustment in State Medicaid Programs***, Health Watch (Health Section, Council of the Soc'y of Actuaries, Schaumburg, Ill.), Jan. 2008, at 14 ("Risk adjustment is a critical tool for the development and sustainability of Medicaid Managed Care Programs."); America's Health Ins. Plans, ***State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations*** (Apr. 2010), http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf (last visited Jan. 26, 2012).[19]

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[19] Private petitioners contend that the Act's insurance reforms "will raise insurance costs in the individual market by *27 to 30%*." NFIB Br. 11 (citing Pet. App. 126a n.107) (citing in turn CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and*

3. Private petitioners invite this Court to immerse itself in the politics of the Act's passage and invalidate the entire statute on the ground that, according to private petitioners, there would not have been 60 votes in the Senate in March 2010 to end a hypothetical filibuster of a hypothetical amended Act without a minimum coverage provision. See NFIB Br. 56-61. Severability involves a question of statutory construction, not an exercise in parliamentary probabilities. The supposed political currents and subjective motivations of individual legislators has never formed part of this Court's

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Affordable Care Act 6 (Nov. 30, 2009) (*Health Insurance Premiums*)). That is a mischaracterization of CBO's finding. CBO found that, relative to a baseline without ACA, premiums under ACA in the large group market would be unchanged or decline by up to 3%; in the small group market would range from a 2% decline to a 1% increase; and in the individual market would increase by 10%-13%. *Health Insurance Premiums* 5. (CBO further found that 57% of persons in the individual market would receive subsidies, and that for those individuals, the average premiums after accounting for subsidies would *decline* by 56% to 59%. *Ibid.*) CBO explained that the "difference in unsubsidized premiums" in the individual market "is the *net* effect of three changes." *Id.* at 6 (emphasis added). Private petitioners misleadingly cite only one of those three changes, ignoring the 7%-10% decline attributable to "net reduction in costs that insurers incurred to deliver the same amount of insurance coverage to the same group of enrollees" and the further 7%-10% decline from "a shift in the types of people obtaining coverage." *Ibid.* And private petitioners mischaracterize the one number they cherry-pick: As CBO explained, the 27%-30% increase in premiums (largely offset by the two declines described above, and completely offset for those receiving subsidies) is attributable to the fact that policies in the individual market will "cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider range of benefits," based in part on *voluntary* decisions "to purchase more extensive coverage." *Ibid.* In other words, some costs that the insured had previously paid out-of-pocket would instead be covered by premium payments.

severability analysis. To the contrary, in *New York*, this Court explicitly recognized that the statute before it, "like much federal legislation, embodies a compromise among the States." 505 U.S. at 183. Nonetheless, the Court held that other provisions of the statute were severable from the provision it invalidated. See *id.* at 186-187.

Rather than the sort of politically-oriented analysis of internal congressional procedures petitioners urge, the Court's severability precedents call for an objective and substantive inquiry, under which it "must retain" all provisions of a statute that are "consistent with Congress' basic objectives in enacting" it. *Booker*, 543 U.S. at 258-259. The task for the Court is to discern, based on tools of statutory construction, what the Congress that actually passed the Act (however large the majority of the Members who voted for it in either House) would have intended if, after passage, a court were to hold a particular provision unconstitutional. See *id.* at 265 (Court must determine Congress's likely intent in light of Court's constitutional holding). Petitioners have pointed to nothing in the Act to suggest that the Congress that passed it would have wanted the entire set of independent measures to fall if one of them was held unconstitutional.

4. Petitioners note that the Affordable Care Act itself has no severability clause, *e.g.*, NFIB Br. 58, but both Houses' drafting manuals expressly provide that such clauses are "unnecessary" and thus need not be included in legislation. Office of the Legislative Counsel, U.S. Senate, *Legislative Drafting Manual* § 131, at 49 (1997); Office of the Legislative Counsel, U.S. House of Representatives, *House Legislative Counsel's Manual on Drafting Style* § 328, at 33 (1995). The absence

of an "unnecessary" provision has no significance, and this Court has said that the "ultimate determination of severability will rarely turn on the presence or absence of such a clause," *Jackson*, 390 U.S. at 585 n.27.

Moreover, there already *are* severability provisions in the Internal Revenue Code, in which Congress not only placed the minimum coverage provision (and many other parts of the Act) but also expressly provided for the applicability of many of the Act's insurance reforms to group health plans, 26 U.S.C. 9815; the Social Security Act, home to the Act's Medicare and Medicaid amendments, among others; and ERISA, which Congress also amended to expressly provide for the applicability of many of the Act's insurance reforms to group health plans, 29 U.S.C. 1185d. See 26 U.S.C. 7852(a) (2006); 42 U.S.C. 1303 (2006); 29 U.S.C. 1139 (2006). Congress triggered those provisions when it added core provisions of the Affordable Care Act to those pre-existing Acts. Congress thus passed the Act against background rules of *severability* applicable under several of the major statutory schemes affected.

Private petitioners rely on what they incorrectly describe as "the *deletion* of a severability clause from an earlier version of the bill" to support their assertion that "Congress intended this unique legislative deal to rise or fall as a whole." NFIB Br. 29. There was no such "deletion." Private petitioners presumably refer to H.R. 3962, a health care reform bill passed by the House in November 2009. 155 Cong. Rec. H12623, H12967-H12968 (daily ed. Nov. 7, 2009). The Senate never considered that measure, much less made "deletions" from it, instead using a different House bill, H.R. 3590, as the vehicle for the Senate's own health care reform legislation. 155 Cong. Rec. S13890-S13891 (daily ed. Dec. 24, 2009).[20] The House then passed that Senate bill. 156 Cong. Rec. H1891, H1920-H2169 (daily ed. Mar. 21, 2010). Even if the absence of a severability provision in the Senate-enacted bill could somehow be construed as a "deletion," the "unexplained disappearance" of text during the progress of a bill is rarely a "reliable indicator[] of congressional intent." *Mead Corp.* v. *Tilley*, 490 U.S. 714, 723 (1989).

C. The Guaranteed-Issue And Community-Rating Provisions That Take Effect In 2014 Are Inseverable From The Minimum Coverage Provision

Congress enacted the Affordable Care Act to expand access to health care services and control health care costs. One set of provisions in the Act to advance these goals addresses defects in the individual market for health insurance. Key reforms in that market are the Act's guaranteed-issue and community-rating provisions, see notes 5 and 6, *supra*, which will end discriminatory insurance practices that have denied affordable coverage to millions of individuals because of their medical conditions or histories. As the government explains in its minimum coverage brief (at 28-30), and as petitioners concede (States' Br. 12, 47; NFIB Br. 36-40), the minimum coverage provision is necessary to make those reforms effective. Congress's findings expressly state that enforcement of those provisions without a minimum coverage provision would *restrict* the availability of health insurance and make it *less* affordable—the opposite of Congress's goals in enacting the Affordable Care Act. Accordingly, in contrast to the rest of the Act (discussed in Point II.B., *supra*), it *is* evident that Congress would not have intended the guaranteed-issue and community-rating provisions to take effect in 2014 if the minimum coverage provision were held unconstitutional, and those provisions accordingly are inseverable from it.

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[20] A comprehensive analysis of differences between the House and Senate health care reform bills at the time made no mention of the absence of a severability clause in the Senate bill. See Tri-Comm. House Staff, *House-Senate Comparison of Key Provisions* (Dec. 29, 2009). That is entirely consistent with both chambers' view of such clauses as unnecessary and entirely inconsistent with private petitioners' theory that the Senate deliberately omitted such a provision because it wanted the entire Act to fall if any of its provisions was invalidated.

1. Congress's findings establish that the guaranteed-issue and community-rating provisions are inseverable from the minimum coverage provision. Congress specifically found that in a market with guaranteed issue and community rating, but without a minimum coverage provision, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C.A. 18091(a)(2)(I).[21] Congress then found that

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[21] The relevant sentence says in full: "Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), many individuals would wait to purchase health insurance until they needed care." 42 U.S.C.A. 18091(a)(2)(I). Section 2704 of the Public Health Service Act (as added by Section 1201 of ACA) prohibits insurers from excluding individuals from coverage based on preexisting conditions. See 42 U.S.C. 300gg-3. Section 2705 of the Public Health Service Act (as added by Section 1201 of ACA), prohibits coverage eligibility rules based on "health status-related factors," 42 U.S.C. 300gg-4(a), and prohibits insurers from charging higher premiums to similarly-situated individuals and dependents within a group based on such factors, 42 U.S.C. 300gg-4(b). See ACA § 1201(3)(A), 124 Stat. 154 (adding "individual" market to pre-existing prohibition on charging such differential premiums based on health status-related factors in group market); ACA § 1201(3)(B), 124 Stat. 155 (transferring that provision to redesignated Public Health Service Act Section 2705, 42 U.S.C. 300gg-4(b)); ACA § 1201(4), 124 Stat. 156 (adding prohibition on eligibility rules to Section 2705, 42 U.S.C. 300gg-4(a)).

"[b]y significantly increasing health insurance coverage," the minimum coverage provision, "together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Ibid.* Congress therefore expressly found that the minimum coverage provision is "*essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Ibid.* (emphasis added); see 42 U.S.C.A. 18091(a)(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.").

The guaranteed-issue and community-rating provisions ensure that all individuals have access to health insurance priced according to community-wide rates, rather than individual risk factors. Congress understood that, in a market governed by those provisions but lacking a minimum coverage provision, healthy individuals have an incentive to stay out until their need for insurance arises while, at the same time, those with the most serious immediate health care needs have a strong incentive to obtain coverage. Premiums would therefore go up, further impeding entry into the market by those currently without acute medical needs, risking a "marketwide adverse-selection death spiral," Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, Health Affairs, July/Aug. 2004, at 167, 169, and restricting the availability of affordable health insurance—the opposite of what Congress intended. It is evident that Congress would not have intended the guaranteed-issue and community-rating reforms to stand if the minimum coverage provision that it twice described as "essential" to their success, 42 U.S.C.A. 18091(a)(2)(I) and (J), were held unconstitutional.

2. Congress had firm empirical support for its conclusion that the minimum coverage provision is essential to make the guaranteed-issue and community-rating reforms effective.

a. As evidence before Congress demonstrated, a number of States had enacted guaranteed-issue and community-rating requirements without a minimum coverage provision. "The result in each State was a general destabilization of individual markets, increases in premiums, and declining enrollment." AHIP Amicus Br. 27; see State's Br. 8-9; Maryland Minimum Coverage Amicus Br. 22 (Maryland Amicus Br.); American Ass'n of People with Disabilities Minimum Coverage Amicus Br. 8-13. Based on this record, Congress understood that, "if you put those two mandates on the [insurance] industry," *i.e.*, guaranteed issue and community rating, "you must also mandate the individual to be insured or the market will blow up, as it has in New Jersey" and other States. *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the House Comm. on Ways & Means*, 111th Cong., 1st Sess. 9 (2009) (Professor Uwe E. Reinhardt, Princeton Univ.) (*House Hearing*); see Uwe E. Reinhardt, *Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the House Comm. on Energy & Commerce*, 111th Cong., 1st Sess. 11 (Mar. 17, 2009) ("It is well known that community-rating and guaranteed issue coupled with voluntary insurance tends to lead to a death spiral of individual insurance.").

Indeed, the National Association of Insurance Commissioners expressly warned Congress that "[s]tate regulators [could] support" national guaranteed-issue reforms only "to the extent they [were] coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable." *Roundtable Discussions on Comprehensive Health Care Reform: Hearings Before the Senate Committee on Finance*, 111th Cong., 1st Sess. 504 (2009) (Sandy Praeger, Kansas Comm'r of Ins., on behalf of the National Ass'n of Ins. Comm'rs); see *id.* at 74 (Praeger) (reform must pair guaranteed issue and community rating with minimum coverage provision because "otherwise you will just wait until you are sick and then buy the coverage").

Illustrative examples from the States are discussed below:

Washington. "Washington actually experienced the 'death spiral' that can occur in the private insurance market when coverage for preexisting conditions is required without universal coverage." Governor of Wash. Minimum Coverage Amicus Br. 11. In 1993, that State prohibited insurers in the individual market from rejecting applicants based on health status. *Ibid.* Premiums rose, and "the major carriers in Washington stopped selling individual plans, leading to the virtual destruction of the individual insurance market." *Id.* at 11-12; see AHIP Amicus Br. 30 (premiums in individual market in Washington rose by as much as 78% in three years, and enrollment fell by 25%). In addition, Washington "became a magnet for patients from around the country who had serious and expensive medical conditions because they knew they could get immediate health insurance coverage." Doug Ericksen & Roger Stark, *What*

Washington, D.C. Could Learn from Washington State on Health Care Reform, Inside ALEC, July 2010, at 21. In 2000, after the only two remaining insurers in the individual market threatened to withdraw, Washington "was forced" to restructure the insurance reforms by once again allowing insurers to deny coverage based on health status. Governor of Wash. Minimum Coverage Amicus Br. 12.

Kentucky. After Kentucky adopted guaranteed-issue and modified community-rating reforms in 1994 without a minimum coverage provision, "40 insurers departed the Commonwealth, leaving only two remaining providers to serve the statewide market." Maryland Amicus Br. 22. In 1997, the state department of insurance called for legislative changes out of "[c]oncern over a possible impending death spiral" in the individual insurance market, and in 1998 the legislature repealed many of the reforms, including guaranteed issue and community rating. Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. Health Pol. Pol'y & L. 133, 155, 158 (2000).

New Hampshire. In 1994, New Hampshire adopted guaranteed-issue and modified community-rating reforms without a minimum coverage provision. David Sky, *High Risk Pool Alternatives: A Case Study of New Hampshire's Individual Health Insurance Market Reforms*, 16 J. Ins. Reg. 399, 400-401 (1998). As a result, there was a "market-wide antiselection spiral," *id.* at 401; all but two insurers withdrew from the State; and premiums increased. AHIP Amicus Br. 29. The State repealed the guaranteed-issue requirement in 2001 and "allowed insurers once again to use medical underwriting for policies sold in the individual market." *Ibid.*

Maine. After Maine in 1993 enacted guaranteed-issue and modified community-rating rules without a minimum coverage provision, the market for individual coverage entered a "death spiral." Maine Bureau of Ins., *White Paper: Maine's Individual Health Insurance Market* 1, 4, 10 (Jan. 22, 2001). Premiums skyrocketed; participation in the individual market plummeted from 102,000 in 1994 to 54,000 in 2000; and most insurers withdrew from the State. *House Hearing* 117 (Phil Caper, M.D., and Joe Lendvai); AHIP Amicus Br. 27.[22]

Massachusetts. In 1996, Massachusetts adopted guaranteed-issue and modified community-rating reforms without a minimum coverage provision. See Blue Cross & Blue Shield of Mass. Minimum Coverage Amicus Br. 11-12. Just as in other States that followed that course, premiums increased and coverage decreased. See *id.* at 12 (enrollment in individual market fell from approximately 135,000 in 1996 to just over 55,000 in 2000). Rather than repealing the insurance reforms, however, Massachusetts in 2006 maintained them and added a minimum coverage provision in order to "prevent the problems of adverse selection, so-called free riders, and associated cost-shifting from defeating the goal of comprehensive health reform." *Id.* at 13. As a result, Massachusetts now has the lowest proportion of uninsured residents in the Nation. Jon Kingsdale, Executive Dir., Commonwealth Health Ins. Connector Auth., *Prepared Statement for Making Health Care Work for American Families: Hearing Before the Subcomm. on Health of the House Comm. on Energy & Commerce*, 111th Cong., 1st Sess. 1 (Mar. 17, 2009); Mass. Minimum Coverage Amicus Br. 3, 9, 11. Congress specifically found that "despite the economic downturn, the number of workers offered employer-based coverage" in Massachusetts after it adopted its "similar" minimum coverage provision "has actually increased." 42 U.S.C.A. 18091(a)(2)(D).

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[22] Other States that in the 1990s enacted guaranteed-issue and community-rating reforms without a minimum coverage provision experienced similar destabilization. AHIP Amicus Br. 32-33 (discussing New Jersey, New York, and Vermont); Pet. App. 230a-231a (Marcus, J., dissenting); see also Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & L. 71, 91-92 (2000) ("There was a dramatic exodus of indemnity insurers from New York's individual market."); *House Hearing* 101-102 (Professor Uwe E. Reinhardt, Princeton Univ.) (New Jersey).

3. The court of appeals cited a number of reasons for its conclusion that the minimum coverage provision is severable from the guaranteed-issue and community-rating provisions, but none of them has merit.

a. The court of appeals correctly observed that the Act "include[s] other provisions," separate from the minimum coverage provision, that serve the statute's overall goal of "reduc[ing] the number of the uninsured by encouraging or facilitating persons (including the healthy) to purchase insurance coverage." Pet. App. 181a. The court included on that list a number of provisions that are indeed severable for that very reason, including those instituting the health insurance exchanges, federal premium tax credits, federal cost-sharing reduction payments, and the employer responsibility provision. See *ibid.* The court never explained, however, why the existence of those provisions would have led Congress to adopt guaranteed-issue and community-rating reforms without a minimum coverage provision, in light of the well-documented problem of adverse selection in the individual market that would inevitably result from such a scheme.

b. The court of appeals, applying what the dissent below correctly characterized as a form of strict scrutiny review, see Pet. App. 218a, concluded that Congress's choices in structuring the minimum coverage provision "serve[d] to weaken [its] practical influence on the two insurance product reforms." *Id.* at 183a. The court was apparently of the view that, because of the minimum coverage provision's exceptions and enforcement features, it would not be especially effective in stemming adverse selection in a guaranteed-issue and community-rated insurance market, such that invalidating that provision would not make much difference in the success of those insurance reforms. See *id.* at 182a-183a. That analysis was misconceived. The question of severability is one of congressional intent, and Congress expressly found that the minimum coverage provision is "essential" to the guaranteed-issue reforms. 42 U.S.C.A. 18091(a)(2)(I). Whatever the court of appeals might have thought, Congress's judgment controls.

In any event, the court of appeals was wrong in its assessment of the minimum coverage provision's effectiveness. In CBO's expert judgment, by 2019, the Act will reduce the number of non-elderly individuals without insurance by approximately 33 million, resulting in 95% of Americans having coverage (up from 83% today). CBO has attributed about half of that projected decrease in the number of non-elderly uninsured—16 million people—to the direct and indirect effects of the minimum coverage provision. *CBO's March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act* 1 (Mar. 18, 2011); *CBO's June 2010 Analysis* 2; see States' Br. 46 (acknowledging that half the reduction in the number of uninsured under the Act results from minimum coverage provision); see also Matthew Buettgens & Caitlin Carroll, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care* 7 (2012) (with minimum coverage provision, number of uninsured will fall by 24 million; without it, reduction would be eight to ten million).

The court of appeals also thought that enforcement of the minimum coverage provision would be "toothless." Pet. App. 183a. But the court disregarded that the IRS may employ, among other tools, offsets against federal tax refunds to collect minimum-coverage-provision penalties, a highly effective method of collection. See 26 U.S.C. 6402(a); Gov't Minimum Coverage Br. 54. In any event, it is once again *Congress's* judgment that controls. After balancing competing considerations, Congress concluded both that the guaranteed-issue and community-rating provisions that take effect in 2014 would be viable only with the minimum coverage provision, and that the applicable enforcement measures would be sufficient to give the necessary force to that provision.

The court of appeals' assessment of the effectiveness of the minimum coverage provision suffered from other basic errors. The court thought that the provision's effectiveness was limited by its exceptions, and posited that "illegal aliens *and other nonresidents*" are exempt from the provision. Pet. App. 127a, 183a (emphasis added). Yet that latter group (non-citizens legally in the country) is not exempt. See 26 U.S.C. 5000A(d)(3). The court of appeals also questioned whether the provision would actually expand coverage, on the view that "the cost-shifter uninsured who cannot pay the average $2,000 medical bill also cannot pay the average $4,500 premium." Pet. App. 128a. That assertion completely ignored the provisions in the Act—discussed elsewhere in the majority's opinion—that furnish refundable tax credits to reduce premium costs for certain low- and moderate-income households. *Id.* at 36a-37a; see *id.* at 36a n.45 ("For a family of four with an income of $33,075 per year, * * * the federal tax credit would be $3,177 per year."); see also Economic Scholars Minimum Coverage Amicus Br. 25-29 (discussing multiple errors in an amicus brief relied upon by Eleventh Circuit in making its judgment about effectiveness of minimum coverage provision).

* * * * *

In sum, if the Court invalidates the minimum coverage provision and concludes that there are no impediments to its reaching the question of severability, it should invalidate only the guaranteed-issue and community-rating provisions that take effect in 2014 as non-severable. The statutory provisions to be invalidated in that event, in addition to 26 U.S.C. 5000A(a)-(d) and (g), are 42 U.S.C. 300gg(a)(1), 300gg-1, 300gg-3 (with respect to adults, see note 5, *supra*), and 300gg-4(a) and (b), as added, or redesignated and amended, by the Affordable Care Act.[23]

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[23] In the event the Court affirms the court of appeals' judgment on the constitutionality of the minimum coverage provision, 26 U.S.C. 5000A(a) and (b) would be invalidated. Subsections (c) (amount of penalty), (d) (individuals to whom penalty applies), and (g) (procedure for imposing penalty) would then have no application. Subsections (e) (exemptions) and (f) (various statutory definitions) would have no application to the minimum coverage provision itself, but those subsections also define terms used in other provisions of the Act that do not involve the minimum coverage provision. See, *e.g.*, 26 U.S.C. 6056(f)(1)(A) (definitional provision of employer reporting requirement cross-referencing definitional provision in 26 U.S.C. 5000A(e)(1)(B)(i)); 42 U.S.C.A. 18011(a)(4)(B)(ii) (requiring grandfathered group plans to

CONCLUSION

In the event the Court invalidates the minimum coverage provision, it should vacate the court of appeals' judgment addressing the severability of provisions of the Act that do not apply to petitioners or are subject to statutory bars to review. To the extent the Court reaches the issue of severability, it should reverse that portion of the judgment of the court of appeals finding the minimum coverage provision severable from the guaranteed-issue and community-rating provisions, but otherwise affirm the judgment of the court of appeals finding the minimum coverage provision severable from the remainder of the Act.

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extend dependent coverage until age 26 based in part on whether child has access to employer-sponsored plan of his own that meets the definitions in 26 U.S.C. 5000A(f)(2)). Therefore, Subsections (e) and (f) of Section 5000A should be severed if the Court were to declare the minimum coverage provision unconstitutional.

In the event the Court reaches the question of the severability of the guaranteed-issue and community-rating provisions, only those provisions identified above and previously, see notes 5 and 6, *supra*, would be invalidated (with the exception of Section 300gg-3 as applicable to individuals under 19, a requirement that is in effect now, see note 5, *supra*, and thus was plainly intended to be severable from the minimum coverage provision). By contrast, 42 U.S.C. 300gg(a)(2) (involving "rating areas") would be severable because that provision is cross-referenced in sections of the Act that do not involve the community-rating requirement. See, *e.g.*, 42 U.S.C.A. 18051(a)(2)(A)(i) (defining eligibility for participation in optional state health program for low-income individuals not eligible for Medicaid based in part on individual's premium cost "in the rating area in which the individual resides"). In addition, pre-Affordable Care Act statutes regulating the group market, see Gov't Minimum Coverage Br. 5, would obviously not be invalidated and would return in their pre-Act form. See *Frost* v. *Corporation Comm'n*, 278 U.S. 515, 526-527 (1921).

Respectfully submitted.

DONALD B. VERRILLI, JR.
Solicitor General

TONY WEST
Assistant Attorney General

EDWIN S. KNEEDLER
Deputy Solicitor General

BETH S. BRINKMANN
Deputy Assistant Attorney General

JOSEPH R. PALMORE
Assistant to the Solicitor General

MARK B. STERN
ALISA B. KLEIN
ANISHA DASGUPTA
DANA KAERSVANG
Attorneys

GEORGE W. MADISON
General Counsel
Department of the Treasury
Washington, D.C. 20220

M. PATRICIA SMITH
Solicitor of Labor
Department of Labor
Washington, D.C. 20210

WILLIAM B. SCHULTZ
Acting General Counsel

KENNETH Y. CHOE
Deputy General Counsel
Department of Health and Human Services

JANUARY 2012

APPENDIX

1. 26 U.S.C. 5000A (Supp. IV 2010) provides:

Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment.—

(1) In general.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty.—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) **Amount of penalty.**—

(1) **In general.**—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) **Monthly penalty amounts.**—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) **Flat dollar amount.**—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount.—For purposes of paragraph (1)—

(A) In general.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in.—The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(4) Terms relating to income and families.—For purposes of this section—

(A) Family size.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income.—The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) **Modified adjusted gross income.**—The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

[(D) **Repealed**. Pub. L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(d) **Applicable individual.**—For purposes of this section—

(1) **In general.**—The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) **Religious exemptions.—**

(A) **Religious conscience exemption.**—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) **Health care sharing ministry.—**

(i) **In general.**—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) **Health care sharing ministry.**—The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions.—No penalty shall be imposed under subsection (a) with respect to—

(1) **Individuals who cannot afford coverage.**—

(A) **In general.**—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) **Required contribution.**—For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) **Special rules for individuals related to employees.**—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to[1] required contribution of the employee.

(D) **Indexing.**—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) **Taxpayers with income below filing threshold.**—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

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[1] So in original. Probably should be followed by "the".

(3) **Members of Indian tribes.**—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) **Months during short coverage gaps.**—

(A) **In general.**—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) **Special rules.**—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) **Hardships.**—Any applicable individual who for any month is determined by the Secretary of Health

and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage.—For purposes of this section—

(1) In general.—The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs.—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;[2]

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

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[2] So in original. The semicolon probably should be a comma.

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) **Employer-sponsored plan.**—Coverage under an eligible employer-sponsored plan.

(C) **Plans in the individual market.**—Coverage under a health plan offered in the individual market within a State.

(D) **Grandfathered health plan.**—Coverage under a grandfathered health plan.

(E) **Other coverage.**—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) **Eligible employer-sponsored plan.**—The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) **Excepted benefits not treated as minimum essential coverage.**—The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) **Individuals residing outside United States or residents of territories.**—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) **Insurance-related terms.**—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure.—

(1) In general.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules.—Notwithstanding any other provision of law—

(A) Waiver of criminal penalties.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

2. 42 U.S.C. 300gg (Supp. IV 2010) provides:

Fair health insurance premiums

(a)[1] Prohibiting discriminatory premium rates

(1) In general

With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 300gg-6(c) of this title); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) Rating area

(A) In general

Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this subchapter.

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[1] So in original. No subsec. (b) has been enacted.

(B) Secretarial review

The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this subchapter. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

(3) Permissible age bands

The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) Application of variations based on age or tobacco use

With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) Special rule for large group market

If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 18032(f)(2)(B) of this title), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

3. 42 U.S.C. 300gg-1 (Supp. IV 2010) provides:

Guaranteed availability of coverage

(a) Guaranteed issuance of coverage in the individual and group market

Subject to subsections (b) through (e)[1], each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

(b) Enrollment

(1) Restriction

A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

(2) Establishment

A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 1163 of Title 29).

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[1] So in original.

(3) Regulations

The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

(c) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals[2] employees and dependents.

(2) 180-day suspension upon denial of coverage

An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

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[2] So in original

4. 42 U.S.C. 300gg-3 (Supp. IV 2010) provides:

Prohibition of preexisting condition exclusions or other discrimination based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1)[1] of this section in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f) of this section.

(4) Waiting period

The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

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[1] See References in Text note below.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this subchapter, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq. 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].

(E) Chapter 55 of Title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of Title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg-91(c) of this title).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group or individual health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4) of this section, any period that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2) of this section) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-eligible individuals

In the case of plan years beginning before February 13, 2011—

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of title 26 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions

The terms "TAA-eligible individual" and "TAA-related loss of coverage" have the meanings given such terms in section 300bb-5(b)(4) of this title.

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3)[2] of this section, a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

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[2] See References in Text note below.

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3) of this section based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) Issuer notice

In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the individual or group group[3] market, the issuer—

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) of this section or in such other manner as may be specified in regulations.

(d) Exceptions

(1) Exclusion not applicable to certain newborns

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

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[3] So in original.

(3) Exclusion not applicable to pregnancy

A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage

(1) Requirement for certification of period of creditable coverage

(A) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits

In the case of an election described in subsection (c)(3)(B) of this section by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods

(1) Individuals losing other coverage

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries

(A) In general

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules for application in case of Medicaid and CHIP

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage

The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP

The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Coordination with Medicaid and CHIP

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage

(I) In general

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], or child health assistance under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 1181(f)(3)(B)(i)(II) of Title 29.

(II) Option to provide concurrent with provision of plan materials to employee

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 1024(b) of Title 29.

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.], the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance[4] Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social

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[4] So in original. Probably should be followed by the word "Program".

Security Act [42 U.S.C. 1397ee(c)(2)(B), (3), (10)] or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion

(1) In general

A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) "Affiliation period" defined

For purposes of this subchapter, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

5. 42 U.S.C. 300gg-4 (Supp. IV 2010) provides in pertinent part:

Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Secretary.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan, and health insurance issuer offering group health[1] insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

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[1] So in original. Probably should be preceded by "a".

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6. 42 U.S.C.A. 18091 provides:

Requirement to maintain minimum essential coverage

(a) Findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 *et seq.*), the Public Health Service Act (42 U.S.C. 201 *et seq.*), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In *United States v. South-Eastern Underwriters Association* (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

REPLY
BRIEF

No. 11-400

In the Supreme Court of the United States

STATES OF FLORIDA, SOUTH CAROLINA, NEBRASKA, TEXAS, UTAH, LOUISIANA, ALABAMA, COLORADO, PENNSYLVANIA, WASHINGTON, IDAHO, SOUTH DAKOTA, INDIANA, NORTH DAKOTA, MISSISSIPPI, ARIZONA, NEVADA, GEORGIA, ALASKA, OHIO, KANSAS, WYOMING, WISCONSIN, AND MAINE; BILL SCHUETTE, ATTORNEY GENERAL OF MICHIGAN; AND TERRY BRANSTAD, GOVERNOR OF IOWA,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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REPLY BRIEF OF STATE PETITIONERS ON MEDICAID

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
BLAINE H. WINSHIP
Office of the Attorney General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

March 12, 2012 *(Additional Counsel Listed on Inside Cover)*

GREG ABBOTT
Attorney General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

ALAN WILSON
Attorney General
of South Carolina
P.O. Box 11549
Columbia, SC 29211

LUTHER STRANGE
Attorney General
of Alabama
501 Washington Avenue
Montgomery, AL 36130

BILL SCHUETTE
Attorney General
of Michigan
P.O. Box 30212
Lansing, MI 48909

ROBERT M. MCKENNA
Attorney General
of Washington
1125 Washington Street S.E.
P.O. Box 40100
Olympia, WA 98504

JON BRUNING
Attorney General
of Nebraska
KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508
(402) 471-2834

MARK L. SHURTLEFF
Attorney General of Utah
Capitol Suite #230
P.O. Box 142320
Salt Lake City, UT 84114

JAMES D. "BUDDY" CALDWELL
Attorney General
of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804

JOHN W. SUTHERS
Attorney General
of Colorado
1525 Sherman Street
Denver, CO 80203

LAWRENCE G. WASDEN
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720

THOMAS W. CORBETT, JR.
Governor
LINDA L. KELLY
Attorney General
Commonwealth of
Pennsylvania
16th Floor
Strawberry Square
Harrisburg, PA 17120

MARTY J. JACKLEY
Attorney General
of South Dakota
1302 East Highway 14
Pierre, SD 57501

GREGORY F. ZOELLER
Attorney General of Indiana
302 West Washington Street
Indianapolis, IN 46204

SAMUEL S. OLENS
Attorney General of Georgia
40 Capitol Square, SW
Atlanta, GA 30334

MICHAEL DEWINE
Attorney General of Ohio
DAVID B. RIVKIN
LEE A. CASEY
Baker & Hostetler LLP
Special Counsel
30 East Broad Street
17th Floor
Columbus, OH 43215

JOSEPH SCIARROTTA, JR.
General Counsel
Office of Arizona Governor
JANICE K. BREWER
TOM HORNE
Attorney General of Arizona
1700 West Washington
Street, 9th Floor
Phoenix, AZ 85007

WAYNE STENEJHEM
Attorney General
of North Dakota
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

BRIAN SANDOVAL
Governor of Nevada
State Capitol Building
101 North Carson Street
Carson City, NV 89701

MICHAEL C. GERAGHTY
Attorney General
of Alaska
P.O. Box 110300
Juneau, AK 99811

MICHAEL B. WALLACE
Counsel for the
State of Mississippi
by and through Governor
PHIL BRYANT
Wise Carter Child &
Caraway, P.A.
P.O. Box 651
Jackson, MS 39205

DEREK SCHMIDT
Attorney General of Kansas
Memorial Hall
120 SW 10th Street
Topeka, KS 66612

MATTHEW MEAD
Governor of Wyoming
State Capitol
200 West 24th Street
Cheyenne, WY 82002

WILLIAM J. SCHNEIDER
Attorney General of Maine
Six State House Station
Augusta, ME 04333

J.B. VAN HOLLEN
Attorney General of Wisconsin
114 East State Capitol
Madison, WI 53702

TERRY BRANSTAD
Governor of Iowa
107 East Grand Avenue
Des Moines, IA 50319

QUESTION PRESENTED

Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress' spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?

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Lynn A. Baker, ***Conditional Federal Spending After Lopez,*** 95 Colum. L. Rev. 1911 (Dec. 1995)..21

REPLY BRIEF

The federal government's effort to defend the Affordable Care Act's massive Medicaid expansion is remarkable for what it omits. Rather than attempt to show that the ACA does not coerce the States into expanding their Medicaid programs, the federal government takes the extraordinary position that the spending power has no anti-coercion limit and encompasses the power to commandeer the States through coercion. That position cannot be reconciled with the notion that "our federal system preserves the integrity, dignity, and residual sovereignty of the States." *Bond v. United States*, 131 S. Ct. 2355, 2364 (2011).

And because the federal government denies the existence of an anti-coercion limit on the spending power, it offers no real response to the States' argument that the coercive nature of the ACA's massive Medicaid expansion is evident on the face of the Act. It does not—and cannot—deny that Congress provided low-income individuals with no means *other than Medicaid* for complying with the individual mandate. And it never explains how the States' participation in Medicaid can be accurately described as voluntary when it is necessary to satisfy a mandate. Nor does the federal government even try to explain how a State could possibly reject new terms attached to billions of dollars of pre-existing funds under the single largest federal-state spending program in existence—particularly when that would mean forfeiting not only all of the tax dollars already being collected from its residents to fund Medicaid, but also billions in new federal spending that the ACA creates. It instead offers a misplaced policy argument to the effect that States really would be better off accepting the federal conditions.

Rather than engage in a futile effort to deny the coercion at work in the ACA, the federal government accuses the States of seeking to dictate the terms of federal spending and of endangering the constitutionality of other spending legislation. But the States do not claim any right to receive money stripped of federal conditions; they merely insist that the conditions comply with the Constitution. Nor would striking down the uniquely coercive ACA necessarily threaten any other spending program. Not only is Medicaid the largest federal grant-in-aid program, and not only does the ACA leverage existing funds to coerce compliance with new conditions, but the Medicaid expansion's direct link to the individual mandate makes it unique and belies any effort to describe the States' participation as voluntary. The real threat here is not that invalidating the ACA's massive Medicaid expansion will endanger other federal spending programs, but that approving it will endanger our basic federalist structure. If the federal government can coerce States to administer federal programs, by threatening to withhold billions of dollars extracted from in-State taxpayers, then very little is left of the anti-commandeering doctrine. And if Congress can require States to adopt the few policies it cannot impose directly on pain of forfeiting the kind of massive revenue streams implicated by the ACA, then our federal government is one of limited powers in theory, but not in fact.

ARGUMENT

I. The Court Should Reaffirm The Anti-Coercion Limit On Congress' Spending Power.

As the States have explained, *see* States' Br. 24–32, the case for an anti-coercion limit on Congress' spending power is straightforward. Not only has the Court recognized such a limit in *South Dakota v. Dole*, 483 U.S. 203 (1987), but it has also held that "the Constitution simply does not give Congress the authority to require the States to regulate." *New York v. United States*, 505 U.S. 144, 178 (1992). If the Constitution denies Congress the power to compel States to regulate, then it surely forbids "coercive" uses of the spending power that leave States with no choice but to regulate on the terms that Congress prescribes. The federal government resists this conclusion by asserting that even modest limits on coercive use of the spending power would conflict with Congress' appropriations power or put courts in an untenable position. Neither argument has merit. The spending power, like every other congressional power, is a limited one, and the limit on coercive use of that power to force States to regulate is vital to our constitutional structure.

1. The federal government initially resists an anti-coercion limit on the spending power by invoking the specter of States "insist[ing] that money from the Treasury be appropriated" on terms other than those that "Congress has prescribed." Govt.'s Br. 26. The federal government can rest assured that Congress alone can determine *whether* to spend federal funds and which conditions to impose. But

this Court gets the final word when it comes to determining whether the resulting spending legislation complies with the Constitution. If this Court invalidates spending legislation as impermissibly coercive and commandeering, the result is not that the States get to take the money free and clear, or that they get to dictate the terms on which federal moneys are appropriated. Instead, this Court simply vindicates the Constitution by striking down the invalid legislation, and Congress retains its substantial discretion to spend money in a constitutionally valid manner.

That is why the federal government's reliance on *OPM v. Richmond*, 496 U.S. 414 (1990), is so misplaced. *OPM* held that courts may not order Congress to spend funds "in direct contravention of the federal statute upon which [a] claim to the funds ... rest[s]." *Id.* at 424. But the States are not asking the Court to order Congress to continue funding Medicaid, let alone to continue funding it on terms that directly contravene the Medicaid statute. Quite the contrary, the States readily concede that they have no "vested right that the program w[ill] continue indefinitely or upon the same terms." States' Br. 41.

To be sure, if the Court invalidates the ACA's Medicaid expansion, the States presumably will continue to receive federal Medicaid funding at pre-ACA levels based on pre-ACA conditions. But that is not because States will have "unilaterally ... alter[ed] the conditions on which federal funds will be paid out of the Treasury." Govt.'s Br. 37. It is because (as the federal government is quick to point out, *see* Govt.'s Br. 19) invalidating the ACA's *amendments* to Medicaid would not invalidate Medicaid itself.

If, going forward, Congress decides to make *constitutionally valid* amendments to Medicaid—for example, by offering discrete new funds to States willing to take on discrete new obligations—the States will remain obligated to abide by whatever conditions are attached to whatever funds they voluntarily accept. Indeed, Congress retains the option of spending money in ways that do not involve States at all. For example, Congress can spend money directly through federal instrumentalities, as the ACA will do in States that decline to establish exchanges. *See* ACA § 1321(c). But when Congress decides to involve the States, it is not free to treat them as federal instrumentalities that can be ordered around at will. States retain their dignity and residual sovereignty even when they participate in a federal spending program. Congress obtains substantial benefits—in terms of both efficiency and acceptance by a citizenry wary of expanding federal bureaucracy—by spending federal money though States rather than new federal instrumentalities. But to obtain those benefits, Congress must respect the States' sovereignty and give them a real choice to turn down the funds. Any other result not only undermines the States' sovereignty, but also hopelessly blurs accountability between the federal and state governments.

2. The federal government also complains that the anti-coercion principle empowers courts to usurp the States' right to decide "whether promotion of the general welfare would be best achieved ... by entering into a cooperative financial arrangement"

with the federal government. Govt.'s Br. 35. But that argument assumes its conclusion. To the extent that a spending program is truly voluntary, then a decision to invalidate the program would deny States a choice. But when, as here, the federal spending program is not voluntary and coerces state involvement, a judicial role is critical to ensuring that the States retain the voluntary choice that is the entire justification for evaluating spending legislation differently from direct regulatory impositions. The whole point of the anti-coercion limit is to enforce the constitutional requirement that, "by any … permissible method of encouraging a State to conform to federal policy choices, the residents of *the State* retain the ultimate decision as to whether or not the State will comply." *New York*, 505 U.S. at 168 (emphasis added).

The federal government's argument to the contrary rests on the faulty premise that coercion analysis requires courts to assess the onerousness of the *conditions* Congress forces upon the States. It does not. The question is whether the States have a meaningful ability to reject the *inducement* Congress offers, not whether the States are willing or able to comply with the accompanying conditions. *See Dole*, 483 U.S. at 211 (analyzing "whether *the financial inducement* offered by Congress [is] so coercive as to pass the point at which pressure turns into compulsion" (internal quotation marks omitted; emphasis added)); *Madison v. Virginia*, 474 F.3d 118, 128 (4th Cir. 2006) ("the coercion inquiry focuses on the financial inducement" (internal quotation marks omitted)).

The federal government's repeated attempts to debate the policy merits of the ACA thus are a non-sequitur. The ACA is unconstitutionally coercive because it forces States to implement federal policy, not because it forces the States to implement *bad* federal policy. To be sure, the States vigorously dispute the wisdom of the ACA's Medicaid expansion and the federal government's characterization of the Act as some minor adjustment to "address[] existing gaps in Medicaid coverage," Govt.'s Br. 23. But the fact that 26 States simultaneously dispute the wisdom of the ACA's Medicaid expansion and yet have no practical ability to turn down the funds only highlights the coercion.

Nor can the federal government short-circuit the analysis by arguing that the commandeering the ACA effects is not "significantly onerous." Govt.'s Br. 26. That claim blinks reality—no one believes the States' undertakings will be insignificant—but is legally irrelevant in any event. "[T]he Constitution simply does not give Congress the authority to require the States to regulate," either directly or through the spending power. *New York*, 505 U.S. at 178. There is no *de minimis* exception to that rule.

And in reality, there is nothing *de minimis* about the ACA and its transformation of Medicaid. Even States that support the ACA's Medicaid expansion readily concede that it works "a fundamental shift in the program," *Amicus* Br. of Oregon *et al.* 21, transforming Medicaid from a program that serves limited groups of categorically needy into one designed to provide all low-income individuals with the means to comply with an unprecedented mandate to maintain insurance. The federal government attempts to divert attention from that "major philosophical change in the purpose of the program," *id.* at 20, by emphasizing that States may still "choose whether to provide coverage for optional categories of beneficiaries and whether to offer optional benefits to both mandatory and optional beneficiaries." Govt.'s Br. 29. But that simply ignores that the universe of "optional beneficiaries" has been radically reduced (because the coverage of many heretofore optional beneficiaries has become mandatory in order to satisfy the mandate) and that the federal floor above which States may provide optional benefits has been radically raised. *See, e.g.*, ACA § 2001(a) (expanding eligibility to include currently optional individuals), (c)(2)(B) (adding prescription drug coverage and other services to mandatory "benchmark" benefits); *cf.* Kaiser Family Foundation, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options* 12 (Jan. 2012) (estimating that prescription drug coverage accounted for 15% of optional spending in 2007).

Of course, if some States consider expanding Medicaid "an affordable and preferable alternative," Govt.'s Br. 34 (internal quotation marks omitted), then Congress is free to offer, and those States are free to accept, *additional* funds for that purpose—so long as Congress does not couple that offer with the threat to withhold all *existing* funds from States that disagree.[1] Unlike the ACA, such a statute would respect the "central principle of our system of dual sovereignty that the United States and the States will exercise *independent* judgment concerning what spending measures will best promote the public welfare within their respective spheres." Govt.'s Br. 35 (emphasis added).

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[1] That does not mean that the ACA is "constitutional as applied to ... States" that "consent[]" to the coercion. Govt.'s Br. 53.

3. Finally, that there are *other* limits on Congress' spending power provides no basis for abandoning the anti-coercion limit. Any contention to the contrary is conclusively refuted by *Dole*, as the Court considered the coercion challenge raised there only *after* concluding that the condition at issue satisfied the other four limits on Congress' spending power. *See Dole*, 483 U.S. at 211. Moreover, none of the other limits on Congress' spending power

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Congress cannot deprive a State of the right to choose whether to accept federal funds and conditions just because if the State had a choice it would choose to accept. *See New York*, 505 U.S. at 182.

Indeed, if the Court holds the ACA's Medicaid amendments unconstitutional, it should invalidate not just those provisions, but the entire ACA. *See* States' Severability Br. 50–51, 53–56. As the federal government concedes, the Medicaid expansion is "[o]ne of the principal means" by which Congress sought to increase insurance coverage in the ACA. Govt.'s Br. 8. It accounts for fully 50% of the projected increase in coverage under the ACA and is one of the Act's most expensive components. *See* States' Severability Br. 46, 53. As the States have explained elsewhere, *see* States' Severability Br. 27–37, there is no merit to the federal government's argument that the Court may not consider whether those and other factors identified by the States render the Medicaid expansion non-severable. Nor does the expansion's severability from *Medicaid* have any bearing on its severability from *the ACA*. *But see* Govt.'s Br. 52.

addresses its potential to obliterate state sovereignty. Providing States—*and* other potential recipients of federal funds—clear notice of conditions is certainly important, but it is cold comfort if Congress can impose any clear condition—no matter how coercive—on the States. Thus, the only way to ensure that the spending power does not render anti-commandeering principles mere parchment barriers is to reaffirm that whether to implement federal policy in exchange for federal funds must "remain[] the prerogative of the States not merely in theory but in fact." *Dole*, 483 U.S. at 211–12.

II. The ACA's Medicaid Amendments Are Unconstitutionally Coercive.

If there is an anti-coercion limit to the spending power, the ACA's Medicaid expansion clearly violates it. Indeed, as the States illustrated in their opening brief, *see* States Br. 32–53, if the ACA does not cross the coercion line, then no Act of Congress ever will. The federal government's attempts to prove otherwise distort the States' arguments and the ACA itself. First, the States acknowledge that many Medicaid-eligible individuals are exempt from the *penalty* for violating the individual mandate. But they are not exempt from the *mandate* itself. Although the federal government attempts to conflate the two, Congress kept them separate and provided the Medicaid expansion as the only mechanism for most Medicaid-eligible individuals to comply with the mandate. Second, contrary to the federal government's suggestion, the States do not concede that Congress could avoid the coercion problem by enacting the ACA's reconceived version of Medicaid in a single statute. The fact that Congress attempted to hold States' hostage to their past decisions to participate in Medicaid is a clear indicator of coercion, but it is hardly the only one. Finally, because the ACA is uniquely coercive for multiple reasons, holding it unconstitutional need not render existing conditions on Medicaid or other spending programs constitutionally suspect.

A. The Coerciveness of the ACA's Medicaid Amendment Is Clear in the Act Itself.

The coerciveness of the ACA is evident on the face of the Act. Congress created an unprecedented mandate for individuals to obtain health insurance, extended that mandate to individuals who could not afford to purchase such insurance, and provided no mechanism for their mandated compliance other than Medicaid, as expanded and transformed by the ACA. If a State opts out of Medicaid, the Act does not work. There is no alternative means for the Medicaid-eligible to satisfy the mandate. There would be mandated demand without a means of supply. Under those circumstances, to call the ACA's chosen means of supply for low-income individuals—expanded Medicaid—"voluntary" is Orwellian and gives Congress too little credit. Congress did not fail to provide alternative means for these millions of individuals to comply with the mandate through oversight. It did so because it knew the States had no choice but to supply them with Medicaid.

The federal government does not attempt to demonstrate that individuals covered by the expansion have any alternative to Medicaid, or that

Congress ever contemplated the possibility that such an alternative might be necessary. It instead simply insists that those individuals need not comply with the mandate at all. That argument blatantly distorts the statute that Congress enacted.

The federal government claims the ACA "does not 'force[]' low-income individuals to obtain" insurance because Congress exempted many of those individuals from the *penalty* for failure to comply with the mandate. Govt.'s Br. 49. But Congress did not exempt those individuals from the *mandate*. The plain text of the statute forecloses any other conclusion: the mandate requires individuals to maintain qualifying coverage without regard to any penalties, and Congress carefully delineated separate sets of exemptions from the mandate and the penalty, with the former considerably narrower. *Compare* ACA § 1501(b), 26 U.S.C.A. § 5000A(d), *with id.* § 5000A(e); *see also* States' Minimum Coverage Br. 52–57. Moreover, Congress specified that enrollment in Medicaid is a means of satisfying the mandate. *Id.* § 5000A(f)(1)(A)(ii). Individuals are not excused from complying with a law just because they will not be penalized for violating it; suggesting otherwise trivializes the interest of law-abiding citizens in compliance. The ACA unambiguously requires individuals covered by the Medicaid expansion to maintain insurance, and violating federal law is no small matter. The federal government cannot change that fact by abandoning defense of the statute that Congress actually enacted.

Nor can the federal government reconcile its mischaracterization of the ACA with its concession that 6 to 7 million fewer individuals would enroll in

Medicaid without the mandate. *See* Govt.'s Severability Br. 3–4 (citing Cong. Budget Office (CBO), *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010)). The notion that 20% of the total projected increase in insurance coverage attributable to the ACA was nothing more than a happy accident is inconceivable—particularly when Congress' own advisors explained that a mandate would have precisely that effect *with or without a penalty*. *See* CBO, *Key Issues in Analyzing Major Health Insurance Proposals* 53 (Dec. 2008) ("Many individuals ... would comply with a mandate, even in the absence of penalties, because they believe in abiding by the nation's laws."). Indeed, the federal government has admitted in this very case that the mandate applies to individuals "unable to obtain [insurance] without the ... Medicaid eligibility expansion." Govt.'s Mem. Supp. Mot. Summ. J. 1–2 [R.E. 984–85].

In short, there is no escaping the conclusion that the mandate fully applies to individuals covered by the Medicaid expansion, and that Congress provided no means other than that expansion through which those individuals might satisfy the mandate. That was not an oversight. Congress provided no alternative because it was more expedient to *force* the States to supply that need than to devise a federal alternative to fill the gaping hole that would be left in its scheme for "near-universal coverage," ACA § 1501(a)(2)(D), if States were free to decline to transform their Medicaid programs. Congress' motives are understandable—creating a federal alternative capable of satisfying the insurance needs of individuals up to 138% of the federal poverty level would have been an onerous and unpopular undertaking. But the fact that achieving its objectives directly would be difficult does not license Congress to convert States into federal instrumentalities by commandeering them through a coercive use of its spending power.

In all events, the federal government ultimately concedes, as it must, that the ACA is premised on the expectation that the States will continue to participate in Medicaid. Any other reading would compel the untenable conclusion that Congress was agnostic not only as to whether low-income individuals would comply with the mandate, but as to whether they had access to insurance *at all*. The federal government attempts to downplay the significance of its concession by arguing that Congress assumed continued participation because the States have participated in Medicaid for decades. *See* Govt.'s Br. 50–51. But that only underscores the problem. If Congress simply conditioned new money on new conditions, its confidence about continuing participation might be a mere predictive judgment. But when Congress puts billions of dollars in federal funding under a massive and entrenched program at risk, its confidence in continued participation is not mere prognostication. It is coercion.

The federal government alternatively contends that "Congress's perceived expectations have no bearing on the question whether Congress has unconstitutionally coerced the States." Govt.'s Br. 51. To be sure, the ultimate constitutional question remains whether Congress *in fact* coerced the States, not just whether Congress *intended* to do so. But when Congress premises an entire regulatory scheme on the assumption that the States have no choice but to play the part it demands, that is powerful evidence that spending legislation is coercive in both intent and effect—particularly when that assumption is backed by a threat to withhold every penny of federal spending under the largest federal-state aid program in existence. And when Congress mandates that Medicaid-eligible individuals maintain insurance, but provides no alternative means for them to obtain it, it is impossible to label the States' participation in Medicaid voluntary. It is every bit as mandatory as the individual mandate to which it is inextricably linked.

B. Congress Cannot and Did Not Reserve the Right to Make Unconstitutionally Coercive Amendments to Medicaid.

The federal government contends that Congress' reservation of "the right to alter, amend, or repeal any provision" of Medicaid, 42 U.S.C. § 1304, means Congress may "'provide by amendment whatever rules it might have prescribed' in its initial enactment." Govt.'s Br. 39–40 (quoting *Bowen v. Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 54 (1986)). Because the federal government deems it "clear" that "Congress could have included in its initial enactment of the Medicaid Act the entire set of terms and conditions that will be in effect" under the ACA, Govt.'s Br. 47, 40, it maintains there can be no objection to Congress amending Medicaid to reach the same result. That logic is flawed at every turn.

First, the federal government misreads the Court's decision in *Public Agencies*. That was a *takings* case involving whether Congress violated a State's *contractual* rights under the Social Security Act by repealing a statutory provision that allowed States to withdraw their employees from social security. 477 U.S. at 51–52. The Court concluded that the State had no vested property right to take because it had entered into the program "under an Act that contained the language of reservation ... expressly notif[ying] the State that Congress retained the power to amend the law." *Id.* at 54. The Court neither held nor even suggested, however, that Congress' reservation would preclude the State from raising *other* constitutional objections to the amendment. Quite the contrary, the Court expressly noted that no Tenth Amendment claim remained in the case. *See id.* at 50 n.16.

Public Agencies has no bearing on the question before the Court. The States contend that the ACA is unconstitutional because it coerces the States into regulating, not because it effects a taking of a contractual right to continue participating in Medicaid under current terms. The States do not claim a vested right to continued participation under the old terms; they assert a constitutional right not to be coerced into accepting the new terms. They did not and could not forfeit that right by acknowledging their lack of vested rights, and nothing in *Public Agencies* (or any other decision of this Court) is to the contrary. *See New York*, 505 U.S. at 182 ("The constitutional authority of Congress cannot be expanded by the 'consent' of the governmental unit whose domain is thereby narrowed.").

Nor do the States "concede[] that Congress constitutionally could have enacted the Medicaid program at the outset in one statute that contained all of the features of the program as it will exist" under the ACA. Govt.'s Br. 47. To be sure, Congress' exploitation of the States' dependency on existing Medicaid infrastructure and the constituencies that have built up over years of participation underscore the coercion here. And the fact that Congress established new conditions that are clearly distinguishable from the pre-existing program, yet made acceptance of those conditions a requirement of continued participation in the entire program, makes the coercion easy to identify. But if an entirely new program forced States to make the same untenable non-choice between forfeiting billions of federal tax dollars each year or regulating health insurance for the needy according to Congress' dictates, it would pose largely the same constitutional problem. And Congress could not avoid that problem by repealing Medicaid and enacting the ACA's amended version in a single statute. Simply calling it something else would not make it any more constitutional.

More fundamentally, the federal government's erroneous insistence that Congress could achieve the same end through different means is as constitutionally suspect here as it is in its defense of the individual mandate. In theory, Congress might be able to repeal Medicaid and run an insurance program for low-income individuals through a federal bureaucracy with offices in every State. But even if Congress could do that in theory, there are powerful practical *political* impediments to the direct federal takeover of an area of traditional state and local concern. What is more, if those practical constraints could be overcome, the resulting federal program would leave no doubt as to which level of government was responsible for the resulting costs and benefits. Someone with complaints about a federal program could contact a federal office with a federal complaint. The notion that Congress may circumvent political constraints and blur accountability by forcing States to administer this massive new federal undertaking is at considerable odds with the principle that "[f]ederalism serves to assign political responsibility, not to obscure it." *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 636 (1992).

C. The ACA Is Uniquely Coercive.

At bottom, the federal government has no real response to the reality that the sheer amount of funding at stake under the ACA leaves the States with no choice but to acquiesce to Congress' demands. It instead complains that acknowledging the unconstitutionality of the ACA might cast doubt on the constitutionality of other spending legislation. Not so. The ACA and its efforts to leverage the entirety of an expanded Medicaid program in service of the individual mandate are truly unique. Thus, striking down this coercive effort need not threaten any other spending program, but upholding it would sound the death knell for any anti-coercion limit on the spending power.

The ACA's Medicaid expansion is unique in two respects: the amount of funding at stake and the expansion's relationship to the individual mandate. The vast majority of federal spending programs are sufficiently small to make any "argument as to coercion ... more rhetoric than fact." *Dole*, 483 U.S. at 211; *see* States' Br. 56–57. Medicaid, by contrast, was the largest grant-in-aid program to the States *even before its massive expansion by the ACA*. What is more, the program's direct link to the decidedly non-voluntary mandate belies any effort to describe the States' participation as voluntary. Although Congress has imposed mandatory conditions on continued Medicaid participation in the past, none was tied to a novel federal mandate that depended upon its coerciveness, and none expanded funding to the massive levels of the ACA. Thus, whatever questions may have existed as to the constitutionality of aspects of Medicaid before the ACA, this Court need not resolve those questions to resolve this case in the States' favor.

The federal government responds that it "cannot possibly be the law" that adding to the pot of funds makes spending legislation more coercive. Govt.'s Br. 41. But that is both reality and the law. Coercion is measured by a State's ability to withstand the loss of the inducement at stake, not by how invasive the resulting commandeering would be. *See infra*, pp. 6–7. By dramatically increasing the size of the already massive federal Medicaid inducement, the ACA dramatically increases the coerciveness of the threat to withhold it. And the increase truly is dramatic: In the first six years of the expansion's existence, federal Medicaid spending will grow by a whopping ***$434 billion***. *See* Govt.'s Br. 10, 27. The growth will not stop there; federal spending levels will continue to rise as individuals continue to enroll. By the time the expansion is fully phased in, the federal government expects to be providing another $100 billion *each year* in Medicaid funding—nearly a 40% increase over current levels. *See* Letter from Douglas Elmendorf, Director, to the Hon. Nancy Pelosi, Speaker, U.S. House of Reps., Table 4 (March 20, 2010).

The idea that a State could sit on the sidelines while such massive amounts of tax revenues are extracted from its citizens and while the federal government provides no alternative for assisting its low-income residents is complete fiction. It would be one thing if the federal government were expected to spend equivalent amounts on the State's low-income residents if the State did not sign up to be a federal instrumentality (as was the case in *Steward Machine*). And it would be another if this money were collected from a source other than a State's own taxpayers. In either case, the federal government's characterization of the ACA's coercion as "generosity" might be comprehensible. Govt.'s Br. 50. But there is nothing generous—let alone "exceedingly" so, *id.*—about "placing conditions upon the return of" billions of dollars of federal "revenues that were collected from the States' citizenry in the first place." *Va. Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997) (en banc) (plurality opinion of Luttig, J.).

The federal government protests that "[f]ederal taxpayers ... are also citizens of the United States," Govt.'s Br. 43 (internal quotation marks omitted). Exactly. The States are acutely aware that their citizens must pay taxes to two sovereigns, and that increased federal taxes reduce the ability and willingness of their residents to pay additional State taxes. That is precisely why the federal government is being coercive—and not generous—when it extracts revenues from state residents to fund its massive expansion of Medicaid and then withholds those funds from the States unless they "choose" to accept the federal conditions. *See* Lynn A. Baker, *Conditional Federal Spending After Lopez*, 95 Colum. L. Rev. 1911, 1936–37 (Dec. 1995) ("the states implicitly [are] able to tax only the income and property remaining to their residents and property owners after the federal government has taken its yearly share") (footnote omitted)).[2]

That does not mean that *every* condition upon return of federal tax dollars to the States is "constitutionally suspect." Govt.'s Br. 42. Even in the rare instance when an inducement is large enough to raise coercion concerns, spending legislation is not necessarily unconstitutional just because it is coercive. For example, when Congress has the authority to impose a condition *directly*, there is no constitutional impediment to using its spending power to coerce compliance with that condition. *Cf. Pierce County, Wash. v. Guillen*, 537 U.S. 129, 147 n.9 (2003) (rejecting challenge to spending legislation when "Congress had authority under the Commerce Clause to enact" challenged conditions). Thus, nothing in the anti-coercion principle would preclude Congress from coercing state recipients of federal funds to comply with civil rights requirements that fall within Congress' power under section 5 of the Fourteenth Amendment.

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[2] It is no coincidence that questions regarding use of the spending power to coerce the States into regulating did not arise until the 1920s—Congress was largely without the means to attempt to do so until the Sixteenth Amendment authorized the federal income tax in 1913.

The federal government also attempts to obscure the commandeering problem by insisting that the ACA simply imposes conditions on how federal funds may be spent. *See* Govt.'s Br. 16, 24. But that is not a fair or accurate description of the Act. Perhaps the ACA could be said to impose conditions on how States may spend the *new* funds that it provides. But its requirement that States expand their Medicaid programs to cover millions of additional individuals has nothing to do with how States will spend the *existing* funds that the ACA leverages to ensure compliance with its new conditions. As to those funds, the ACA imposes a simple directive to legislate: Unless States extend Medicaid coverage to all individuals up to 138% of the federal poverty level, they may no longer receive billions of dollars in federal funding to help pay for the millions of individuals already enrolled in their Medicaid programs. Because Congress could not just direct the States to expand their Medicaid programs, the potential for commandeering is obvious.

While the ACA is uniquely coercive and thus distinguishable from other spending legislation, upholding it would mean abandoning the notion that "the federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for [the Court] to admit inability to intervene when one or the other level of Government has tipped the scales too far." *United States v. Lopez*, 514 U.S. 549, 578 (1995) (Kennedy, J., concurring). Indeed, it is both telling and troubling that the federal government's arguments are rooted in a case that rejected a coercion argument by reasoning that state sovereignty "is adequately protected by the national political process." *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989); *see also Amicus* Br. of Senate Majority Leader Harry Reid *et al.* 16 (urging rejection of anti-coercion principle because "'State sovereign interests ... are more properly protected by procedural safeguards ... than by judicially created limitations on federal power'" (quoting *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 552 (1985)).

The ACA is Exhibit A that the "national political process" and Congress' "underdeveloped capacity for self-restraint," *Garcia*, 469 U.S. at 588 (O'Connor, J., dissenting), are insufficient to protect States from coercive spending legislation. Federal legislators have no obvious incentive to resist enlarging the federal share of taxes and controlling States by "giving back" some of that revenue only if States agree to the federal legislators' preferred conditions.

In nearly all other contexts, this Court has refused to shrink from the sometimes difficult task of enforcing the Constitution's structural protections. The spending power as envisioned by the federal government threatens to render the limits on every other enumerated power—and the very process of enumeration itself—beside the point. Virtually any power denied to Congress directly could be attached as a condition to massive federal spending. The Constitution's basic structure and the sovereignty of the States are simply too fundamental for this Court to accept the federal government's submission.

CONCLUSION

The Court should hold the ACA's Medicaid expansion unconstitutional and the ACA invalid in its entirety.

Respectfully submitted,

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508

GREG ABBOTT
Attorney General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

March 12, 2012 *Counsel for Petitioners*

REPLY
BRIEF

NOS. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
ET AL.,

v.

KATHLEEN SEBELIUS, ET AL.

STATE OF FLORIDA, ET AL.,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

**On Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit**

REPLY BRIEF FOR PRIVATE PETITIONERS ON SEVERABILITY

KAREN R. HARNED
NFIB SMALL BUSINESS
LEGAL CENTER
1201 F St. NW, Suite 200
Washington, DC 20004

PROF. RANDY E. BARNETT
GEORGETOWN UNIV.
LAW CENTER
600 New Jersey Ave. NW
Washington, DC 20001

MICHAEL A. CARVIN
Counsel of Record
GREGORY G. KATSAS
C. KEVIN MARSHALL
HASHIM M. MOOPPAN
YAAKOV M. ROTH
JONES DAY
51 Louisiana Ave. NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

Counsel for Private Petitioners

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REPLY BRIEF FOR PRIVATE PETITIONERS ON SEVERABILITY

In arguing that the individual mandate is severable from most or all of the ACA, the Government and *Amicus* Farr return over and over to the same themes: Surely the Act, even without the mandate, would be *better than nothing*. After all, it includes *so many* provisions, and most *could operate* on their own. Invalidating these perfectly functional elements of Congress' handiwork would thus be a grave act of *judicial overreach*. Each of these themes, however, is badly misconceived.

That a severed law would achieve some of Congress' goals does not suffice—if severance would also abandon the law's principal purpose, undermine another, distort the scheme, or violate important constraints. Half a loaf is not always better than none; sometimes Congress would choose fruit or meat instead of insufficient bread, especially if the latter's price is too high. Hence the proper inquiry asks if Congress actually would "have enacted th[e valid] provisions independently," *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) ("*FEF*"), and thus considers "whether the statute will function in a *manner* consistent with the intent of Congress," *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987), rather than simplistically relying on the truism that courts ought not invalidate more of a statute "than necessary."

Not all statutory provisions are created equal under this inquiry. The mandate is one of thousands of ACA provisions, but that does not detract from its singular role as the foundational building block for the legislative effort: the coercive broadening of the insurance risk pool; which in turn makes affordable sweeping new regulation of insurers; which in turn enables uniform and acceptable federal premium subsidies; which in turn necessitate the imposition of new taxes and fees; and all of which justifies the imposition of new burdens on States and employers in a scheme of "shared responsibility" for achieving affordable, near-universal coverage. Invalidating a *mere detail* of a legislative scheme may not justify scrapping the entirety, but striking a *fundamental premise*, like the mandate, evidently requires wholesale reworking.

Accordingly, it is irrelevant whether other ACA provisions could operate absent the mandate (and the insurance regulations). Even if a hypothetical Congress *could have* enacted the ACA without those provisions, the actual Congress that enacted the ACA never *would have* departed so significantly from its carefully wrought legislative bargain. All of the objective indicia—from statutory text to historical context—so confirm. The Government fails to rebut Private Petitioners' illustrations of the grave distortions of the Act's fundamental features that would be caused by severing the mandate and principal insurance regulations. For his part, *Amicus* seems to agree that significant distortions would result, but aims to minimize them by retaining even those insurance regulations, notwithstanding Congress' express finding that the mandate was "essential" to their proper functioning.

Hence, the only act of overreach would be for the judiciary to implement a version of comprehensive health-insurance reform that does not remotely resemble the law that Congress enacted—a version under which premiums would skyrocket, coverage would drop, the Government would pay insurers for "discriminatorily" priced policies, and burdens would fall disproportionately on employers and States. Rather than show respect for Congress, such a result would fundamentally alter landmark legislation. Here, preserving the boundary between the judicial and legislative realms means allowing *Congress* to rewrite its *own* statute upon the invalidation of its operational, economic, and political centerpiece.

ARGUMENT

I. THIS COURT CAN AND SHOULD NOW RESOLVE THE SEVERABILITY OF THE INDIVIDUAL MANDATE

The Government's lead argument on severability is that this Court cannot or should not address it. Govt. Severability Br. 14-25. Its theory is that, because not every provision in the 2700-page ACA injures Petitioners, this Court cannot address the survival of those provisions, or should (in its discretion) defer the question. But the Government's novel theory is irrelevant, because it concedes that at least *some* provisions of the Act *do* injure Petitioners, and Petitioners contend that those provisions must fall because the mandate is the lynchpin of the entire Act. In any event, as even *Amicus* agrees, the Government's theory is wrong, because severability is a remedial inquiry meant to effectuate Congress' intent, not to redress a distinct injury to a plaintiff.

A. The Government mounts its justiciability challenge on the premise that many ACA provisions do not burden any parties. If a provision causes no injury, the Government argues, this Court cannot or should not decide whether it is severable. *Id.* 16-19.

But the Government also concedes that State Petitioners "have standing to challenge the Act's employer-responsibility provision" and "expansion of Medicaid eligibility." *Id.* 24. Article III thus indisputably allows this Court to consider whether at least *those* provisions must fall with the mandate. Yet Petitioners' argument for why they must is that the *entire Act* collapses if the mandate is invalidated, given the critical economic, operational, and political role of that provision. *See* Private Petrs. Severability Br. 42-61; State Petrs. Severability Br. 42-51. Therefore, to resolve the validity of the provisions as to which the Government asserts no jurisdictional objection, this Court *must* consider Petitioners' broad contention about the survival of the ACA as a whole. The Government's theory is, therefore, irrelevant.

B. In any event, as even *Amicus* agrees, Farr Severability Br. 19-24, the Government's approach to severability is wrong as a matter of theory and precedent. Severability is a "remedial question." *United States v. Booker*, 543 U.S. 220, 246 (2005). When a plaintiff has standing to challenge a statutory provision, and that challenge succeeds, courts must choose a remedy "compatible with the Legislature's intent." *Id.* There is no jurisdictional obstacle to that selection. Surely if congressional intent were undisputed—*e.g.*, if the law had a *non*-severability clause—a court could and should carry out that direct instruction. *Accord* Farr Severability Br. 21 n.4. Here, nobody disputes that Private Petitioners have standing to challenge the mandate. *See* Pet.App. 8a, 10a; Govt. Mandate Br. 16 n.5. Therefore, the remedial severability question is undoubtedly within this Court's power.

Indeed, for nearly a century this Court has resolved severability disputes without ascertaining whether the plaintiffs were independently injured by each of the law's separate provisions—even where it was apparent that they were not. Perhaps the best example is ***Williams v. Standard Oil Co.***, 278 U.S. 235 (1929), wherein this Court considered whether provisions establishing a "Division of Motors and Motor Fuels" and requiring collection of data could survive invalidation of a price-fixing provision. *Id.* at 242-43. Of course, the parties could not possibly have been injured by the mere *existence* of the agency or by its data collection, but this Court nonetheless invalidated the entire law. *Id.* at 244-45. The Government has not even tried to distinguish *Williams*. *See* Govt. Severability Br. 20 n.10.

Conversely, there is *no* case holding that, before a court can address severability, a plaintiff must show harm from each provision. *Printz v. United States*, 521 U.S. 898 (1997), held only that courts *may* "decline" to address severability if *no* party is injured by *any* of the statute's other parts. *Id.* at 935. Here, in contrast, it is undisputed that at least *some* of the Act's other provisions injure Petitioners. *Supra* at I.A.

Moreover, *Printz* at most recognized a *prudential* rule, yet every relevant prudential consideration here supports resolving severability now. This issue has divided the lower courts, and the Act's sweeping provisions have huge implications for government operations and nearly every participant in the health-insurance and healthcare fields—which is presumably why even the Government recommended that this Court grant certiorari on the question.

C. The Government finally argues that two statutes prevent this Court from considering the severability of certain ACA provisions. Govt. Severability Br. 14-15 & nn.8-9. Again, however, the Government's argument is irrelevant, because those statutes do not even arguably bar consideration of whether the *Medicaid expansion* is non-severable. *Id.* Accordingly, even if a handful of ACA provisions could not formally be invalidated in this case, that cannot prevent Petitioners from arguing that the Act's Medicaid expansion is non-severable because the entire Act must fall with the mandate.

In any event, neither statute bars this Court from invalidating the entire ACA. The Anti-Injunction Act bars suits brought "for the purpose of restraining the assessment or collection of any tax," 26 U.S.C. § 7421(a), but the "purpose" of this suit is to invalidate the mandate's legal requirement to purchase health insurance, not to restrain any taxes. *See* Private Resps. AIA Br. 9-12. Similarly, judicial review is barred for actions "to recover on any claim arising under" the Medicare laws, *see* 42 U.S.C. §§ 405(h), 1395ii, but this suit cannot possibly be so described. Unlike in *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 10 (2000), Petitioners' suit is not designed to compel payment of either past or anticipated future Medicare benefits. That a finding of inseverability may incidentally invalidate a tax or Medicare provision does not mean that this suit has the "purpose" of restraining the tax or constitutes an action "to recover on a Medicare claim."

II. THE GOVERNMENT AND *AMICUS* DISTORT THE LEGAL STANDARD FOR SEVERABILITY BY OVERSIMPLIFYING THE LEGISLATIVE PROCESS

Inseverability is mandated in two circumstances: *first*, if the remaining provisions are not "fully operative as a law"; and *second*, if, regardless, it is "evident that the Legislature would not have enacted [them] ... independently." *FEF*, 130 S. Ct. at 3161. The Government and *Amicus* nominally acknowledge this two-part test. But they deprive the critical second prong of all force by effectively assuming that Congress *always* would have enacted any valid part of its handiwork so long as that part advances, to any degree, any of the law's objectives. That assumption is inconsistent with the caselaw, incongruent with the legislative process, and insensitive to the separation of powers.

A. In conducting the second step of severability analysis, the central question "is whether the statute will function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. Remarkably, the Government never quotes this test, and *Amicus* overtly attacks it as too "broad," suggesting that it cannot be "[t]aken literally." Farr Severability Br. 16. It can and it should.

Contrary to *Amicus*, the *Alaska Airlines* test's implicit "comparison between the judicially modified statute and the statute originally enacted," *id.*, is not only proper but *imperative*. Courts must evaluate whether a severed statute would depart so fundamentally from the law's intended operation to warrant the inference that Congress would have done nothing—or something else entirely—rather than pass such a distorted version. *Alaska Airlines*, 480 U.S. at 685. That is wholly consonant with how other cases have described the inquiry. *See Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006) (asking whether "the legislature would have preferred what is left of its statute to no statute at all"); *Williams*, 278 U.S. at 242 (asking whether Congress "would not have been satisfied with what remains").

B. The *Alaska Airlines* comparison properly accounts for the many reasons why Congress might refuse to pass *independently* a statutory provision that it was willing to enact as part of a *package*. This Court has recognized such factors repeatedly, in precedents both venerable and recent. For example, if the provision does not serve Congress' "dominant aim," Congress would prefer a future comprehensive alternative rather than hybrid half-measures. *See R.R. Ret. Bd. v. Alton R.R. Co.*, 295 U.S. 330, 361-62 (1935); *see also Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191-92 (1999). Likewise, if provisions are "mutually dependent," with some serving "as conditions, considerations or compensations" for others, Congress would not have passed the *quid* absent the *quo*. *Carter v. Carter Coal Co.*, 298 U.S. 238, 313, 316 (1936); *see also Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 561-62 (2001) (Scalia, J., dissenting). Similarly, severing a legislative compromise could shift a scheme's deliberate allocation of benefits and burdens "in a direction which could not have been contemplated" and which was not desired. *Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 637 (1895); *see also Alaska Airlines*, 480 U.S. at 685 (directing consideration of "original legislative bargain").

Accordingly, *Amicus* is fundamentally wrong to assert that severance necessarily "does the least amount of damage" to congressional intent. Farr Severability Br. 11. And the Government is equally wrong to suggest that severance is warranted so long as the remaining provisions would advance any statutory objective. *See* Govt. Severability Br. 26-27. As explained, even where the remaining provisions somewhat advance one purpose of a comprehensive and multi-faceted legislative package, their retention could well conflict with Congress' overall plan.

C. For all these reasons, the separation-of-powers implications of severability should not be overlooked. While severability, used cautiously, can effectuate Congress' intent, applying it in a manner that disrupts the statute's dominant purpose or basic bargains constitutes "legislative work beyond the power and function of the court," *Hill v. Wallace*, 259 U.S. 44, 70 (1922). *Amicus* scoffs at the notion that invalidating an entire statute could be more respectful of Congress than invalidation in part, Farr Severability Br. 15, but it is only *partial* invalidation that risks "substitut[ing], for the law intended by the legislature, one they may never have been willing by itself to enact," *Pollock*, 158 U.S. at 636.

III. CONTRARY TO *AMICUS*, CONGRESS WANTED THE GUARANTEED-ISSUE AND COMMUNITY-RATING RULES TO WORK WITH THE MANDATE OR NOT AT ALL

The Government agrees that, because the Act's guaranteed-issue and community-rating regulations would, without the mandate, "*restrict* the availability of health insurance and make it *less* affordable—the opposite of Congress's goals in enacting the [ACA]," those provisions are inseverable from the mandate. Govt. Severability Br. 45. Indeed, Congress made express its position that the mandate was "essential" to the proper functioning of these regulations, 42 U.S.C.A. § 18091(a)(2)(I), mooting any speculation about legislative intent on this point.

Amicus admits that these insurance regulations were intended "to work together with the [mandate], and likely will operate less ideally without" it, but he nonetheless urges they be severed. Farr Severability Br. 25, 31. This Court should not do so.

A. *Amicus* dismisses as "conjecture" Congress' claim that, without the mandate, guaranteed-issue and community-rating would increase premiums, enable strategic behavior, and potentially cause a "death spiral" for the industry. *Id.* 34. Citing studies that challenge those upon which Congress relied, and experts who disagree with those who testified to Congress, *Amicus* insists that the negative effects of the insurance regulations, even untempered by the mandate, will not be as bad as Congress warned. *Id.* 35-44. His argument is doubly wrong.

1. "Conjecture" about the effects of a law matters—when it is *Congress* doing the conjecturing. Severability doctrine asks whether Congress "would ... have been satisfied with what remains" after the unlawful provision is invalidated, *Williams*, 278 U.S. at 242; that inquiry necessarily requires evaluation of what Congress "conjectured" when it chose to structure the statute as it did. *Amicus* thus repeats the Eleventh Circuit's error in second-guessing empirical evidence on which Congress relied.

Here, Congress made its position known, rendering an express finding that the mandate was "essential," both to prevent strategic gaming of the guaranteed-issue and community-rating rules and to "lower health insurance premiums" by "broaden[ing] the health insurance risk pool." 42 U.S.C.A. § 18091(a)(2)(I). Whatever the merits of the studies *Amicus* now cites, *Congress* for these reasons deemed the mandate critical to the preservation of "effective health insurance markets." *Id.*

Amicus responds that Congress' finding was "not address[ing]" severability. Farr Severability Br. 31. Perhaps not, but whether Congress saw an invalid provision as "essential" to the operation of a valid provision is *exactly* the question that severability doctrine tries to answer. *E.g.*, *Alaska Airlines*, 480 U.S. at 691 (asking "whether Congress regarded the [invalid] clause as essential to" valid provision). *Amicus* insists that Congress would have preferred "an imperfect solution rather than no solution," Farr Severability Br. 33, but since Congress viewed the mandate as an "essential" prerequisite to its chosen solution, guaranteed-issue and community-rating by themselves were not a "solution" *at all*. That is not to say that Congress would have abandoned its efforts to solve the problem of preexisting conditions. But it certainly would have rejected guaranteed-issue and community-rating, standing alone, as an acceptable approach.[1]

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[1] *Amicus* claims that Congress also declared the mandate "essential" to statutes like ERISA. Farr Severability Br. 32-33. Actually, the findings cite ERISA *only* to illustrate the Government's "significant role in regulating health insurance"; they describe the mandate as "essential" to "regulation of the health insurance market"—in the manner explained by the very next finding, relating to the interplay between the mandate and insurance regulations. *See* 42 U.S.C.A. § 18091(a)(2)(H),(I).

2. In any event, *Amicus'* evidence does not demonstrate any disagreement with Congress on the relevant point—that the insurance regulations, without the mandate, would dramatically increase premiums, contrary to congressional intent.

Private Petitioners cited a pre-Act CBO study that found that the Act's insurance regulations alone would increase premiums in the individual market by roughly 30%. *See* Private Petrs. Severability Br. 11. *Amicus* cites three other studies: One predicts increases of 27%. Another estimates the increase at 10%-20%. The third finds that premiums would rise by 12.6%, but that appears to reflect premiums as reduced by federal subsidies; putting subsidies aside (as they merely help *some* people *pay* for premiums, but do not reduce them), the increase is 26.2%-34.9%. Farr Severability Br. 40-41 & n.9. These numbers hardly differ from those used by Petitioners and Congress, and they *confirm* the common-sense conclusion that, without the mandate's subsidy, compelling insurers to sell limitless coverage to the relatively unhealthy at average prices will cause a dramatic increase in premiums—frustrating Congress' goal of affordable care.[2]

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[2] The Government says that the 30% increase would be partially offset by two countervailing reductions, Govt. Severability Br. 40 n.19; but, as CBO explained, those reductions are primarily due to the mandate and resulting influx into the risk pool of new, below-average-cost enrollees, *see* CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6, 13 (Nov. 30, 2009). That, of course, is exactly the point: Without the mandate, the enormous cost of forcing insurers to provide limitless healthcare to the sick would *not* be offset.

Amicus speculates that these premium increases would not cause a "death spiral," Farr Severability Br. 39-40, but Congress' goal was not simply to avoid a death spiral. It was to promote "Affordable Care." And, as noted, there is no dispute that insurance costs would increase considerably if the mandate's subsidy were not available to counteract the inflationary effects of the insurance regulations. Indeed, premiums would rise by approximately $1200 per year in that scenario, Private Petrs. Severability Br. 14 n.15—*more than* the alleged $1000 increase that Congress attributed to "cost-shifting" that would be prevented by the mandate, 42 U.S.C.A. § 18091(a)(2)(F). Congress obviously would not have enacted a "solution" that *raises* insurance premiums *more* than the uncompensated-care "problem" it was purporting to solve.

B. *Amicus* also emphasizes the importance of the insurance regulations in "protect[ing]" patients from "abusive" insurance practices. *See* Farr Severability Br. 25-28. But "no legislation pursues its purposes at all costs." *Rodriguez v. United States*, 480 U.S. 522, 525-26 (1987) (per curiam). "Deciding what competing values will or will not be sacrificed to the achievement of a particular objective is the very essence of legislative choice—and it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Id.* at 526. That is all the more true when, as here, Congress had not one but *two* (inconsistent) primary goals—increasing access to coverage ("Patient Protection") *while also reducing costs* ("Affordable Care")—and single-mindedly furthering one goal would directly undermine the other.

It may be true that a "rational Congress" could so value insuring the unhealthy that it would be willing to accept the resulting increased premiums; some States apparently have done so. Farr Severability Br. 35, 43-44. But the question is whether *this* Congress *would have* made that choice. On that question, the legislative findings (Congress declared the mandate "essential"), congressional record (Senators repeatedly justified the provisions as a package), and historical context (the industry demanded the mandate for its support) all direct that the answer is no; the mandate was an economic and political *quid pro quo* for the insurance regulations. *See* Private Petrs. Severability Br. 3-5, 12-19, 36-40. This Court should not undo that bargain.

IV. CONTRARY TO THE GOVERNMENT, THE ACT CANNOT SURVIVE, AND NEVER WOULD HAVE BEEN ENACTED, WITHOUT ITS UNCONSTITUTIONAL HEART

The Government's position is: thus far but no further. While agreeing that guaranteed-issue and community-rating, without the mandate, "would drive up costs and reduce coverage" and so cannot be severed, Govt. Severability Br. 26, the Government contends that invalidation can stop there. It cannot. The Government's line-drawing is arbitrary, as *other* insurance regulations similarly "would drive up costs and reduce coverage" absent the mandate. More importantly, it is inconceivable that Congress would have enacted anything resembling the current ACA without its most critical, most touted provisions—the principal mechanisms for achieving its predominant goals, without which major components of the law would be operationally and politically distorted.

A. The Government Ignores The Operational And Economic Similarities Among The Act's Various Insurance Regulations

1. As Congress understood and the Government explains, if insurers were compelled to issue coverage to all-comers at average prices, "[p]remiums would therefore go up, further impeding entry into the market." Govt. Severability Br. 46. Those regulations (if imposed alone) would thus "restric[t] the availability of affordable health insurance—the opposite of what Congress intended." *Id.* Only by pairing them with the mandate's nearly $40 billion annual subsidy to insurance companies, Private Petrs. Severability Br. 14, was Congress able to "protect" vulnerable customers from "abuse" while still avoiding dramatic premium increases.

Yet the Government refuses to acknowledge that the very same logic equally links the mandate to the Act's *other* regulations of insurance products, which are packaged together in Sections 1001 and 1201 of Title I of the Act. If insurance companies are forced to cover particular services, or forbidden to impose limits on coverage, or restricted in their use of cost-sharing mechanisms like deductibles, costs will similarly increase, and "[p]remiums would therefore go up, further impeding entry into the market." Govt. Severability Br. 46. The result: "restricting the availability of affordable health insurance—the opposite of what Congress intended." *Id.* Again, as Congress expressly found, the mandate's subsidy counteracts much of this effect by "lower[ing] health insurance premiums" to almost the same extent that the insurance regulations increase them. *See* Private Petrs. Severability Br. 13-14. But, without it, *none* of these regulations would work as intended. *See generally* Economists Severability Br. 9-11 (detailing costs of various insurance regulations and offsetting impact of mandate). Particularly since there is no bright-line rule distinguishing *two* of the costly insurance regulations from the rest, choosing among them constitutes an arbitrary and improper alteration of the Act, akin to improperly "blue pencil[ing]" it, *FEF*, 130 S. Ct. at 3162.

2. The Government ignores this logic entirely, instead knocking down a straw-man—that the insurance regulations would "unfairly burden the insurance industry"—by observing that the industry (in its *amicus* brief) does not ask for these provisions to be invalidated. Govt. Severability Br. 38. Of course, the point is not that Congress wanted to protect *insurers* from *unfair burdens*, but that Congress wanted to protect the *public* from the *unaffordable premiums* that would result. As for why the industry seeks invalidation only of guaranteed-issue and community-rating, those two regulations force insurers to sell to undesirable customers at undesirable prices, while the other insurance regulations merely compel them to sell more expensive products. The latter "burden" can more fully be passed on to customers. But the resulting premium increases—which would be considerable, given that these regulations are estimated to drive up insurers' costs by *billions* of dollars annually, *see* Economists Severability Br. 9-11—explain why Congress would not have enacted these regulations on their own, without the economic *quid pro quo* of the mandate to temper their impact.

3. The Government also observes that certain States impose similar regulations, even without an individual mandate. Govt. Severability Br. 39. That is the same argument that *Amicus* advances against the *Government's* position on guaranteed-issue and community-rating. Farr Severability Br. 43-44. The response is also the same: The inquiry is whether *this Congress*, seeking to reduce costs and expand coverage, *would have* enacted these regulations alone, not whether some legislature somewhere, with different weights assigned to the competing interests, *could have* done so. *Supra* at III.B.

4. The Government suggests that Congress could not have intended the insurance regulations to work exclusively with the mandate, because a few of them take effect *before* it. Govt. Severability Br. 38. That proves nothing: A *quid pro quo* is not any less so if a present *quid* is given for a future *quo*. ACA provisions take effect at various times for many reasons, including budgetary gimmickry. *See* Robert Pear, *Senate Health Care Bill Faces Crucial First Vote*, N.Y. TIMES, Nov. 20, 2009, at A24 ("[T]o help hold down the cost of the bill, Mr. Reid decided to delay the effective date for many provisions ...."). Even if these effective dates *were* meaningful clues to Congress' intent, they still would not support the Government's singling out of guaranteed-issue and community-rating for inseverability: Many *other* insurance regulations—*e.g.*, the prohibition on annual dollar limits, requirements to cover certain services, and limits on cost-sharing—also take effect *only* in 2014, along with the mandate.[3]

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[3] *See* Kaiser Family Found., *Implementation Timeline*, http://healthreform.kff.org/Timeline.aspx.

B. The Government Ignores The Fundamental Significance To The Act Of Its Individual Mandate And Insurance Regulations

More broadly, the Government ignores the principal reason why the *entire Act* must ultimately fall: The provisions that the Government concedes must be stricken are, indisputably, the heart of the statute, the primary means of satisfying its major goals. A legislative centerpiece cannot cavalierly be severed, as if it were a dispensable detail.

To repeat, this Court's cases emphasize the need to weigh "the nature" of the stricken provision, and its role "in the original legislative bargain." *Alaska Airlines*, 480 U.S. at 685. A provision can readily be severed if the statute's "prime object" could be "fully accomplished" without it, *Reagan v. Farmers' Loan & Trust Co.*, 154 U.S. 362, 395-96 (1894); but the opposite is true if the provision played an "integral" role in the law's "predominant purpose," *Mille Lacs*, 526 U.S. at 191-92, or implicated its "dominant aim," *Alton*, 295 U.S. at 361-62. When a bill's *hallmark* is stripped therefrom, it is hardly reasonable to presume that Congress nevertheless would have pressed ahead to enact the remainder.

The Government cannot and does not dispute that the mandate, together with the guaranteed-issue and community-rating regulations, are the heart of the ACA. They play an "integral"—indeed, indispensable—role in reducing both the cost of premiums and the number of uninsured, which were the Act's "predominant purpose[s]." *Mille Lacs*, 526 U.S. at 191-92. It thus cannot be said that the Act's "prime object[s]" would be *remotely* satisfied, much less "fully accomplished," without these provisions.

Reagan, 154 U.S. at 395-96. They were the political focal points and operational building blocks for the entire ACA; relative to them, its other parts were "mere appendants," *Williams*, 278 U.S. at 243-44.

Instead of responding, the Government points to the Act's "myriad" provisions that would remain operative without the mandate. Govt. Severability Br. 28. Its focus is exclusively on *quantity*, but what really matters is the *nature* of these provisions. Many of them are allegedly "unrelated" to the Act's main purposes. *Id.* 30. If so, then *those* provisions, if invalid, could likely be severed from the rest of the Act. But the mandate and "core reforms" of the insurance regulations, Govt. Mandate Br. 24, which are critical to the Act's primary goals, cannot be.

C. The Government Ignores The Distortions That Would Be Caused By Eliminating The Mandate And Insurance Regulations

The foundational significance of the mandate and insurance regulations is corroborated by the operational spill-over effects from their invalidation. Indeed, even *Amicus* concedes that those effects "could not easily be limited" to the stricken provisions. Farr Severability Br. 46. Whereas the Government repeatedly emphasizes the undisputed point that most of the Act's components could continue on their own to operate in *some* fashion, e.*g*., Govt. Severability Br. 12, 13, 26, 29, it barely even attempts to respond to Private Petitioners' showing that those components will cease to "function in a *manner* consistent with the intent of Congress," *Alaska Airlines*, 480 U.S. at 685.

1. Private Petitioners have explained that, without the individual mandate, guaranteed-issue,

and community-rating, the Act's scheme of federal premium subsidies would *pay* for the very insurance practices that Congress sought to *proscribe*. Private Petrs. Severability Br. 49-50. The Act's subsidies are calculated based on the lesser of (i) premiums paid or (ii) the community-rated premium for the second-cheapest "silver" plan in the applicable "rating area." *Id.* The Government's attempt to explain how it could calculate the latter figure—notwithstanding invalidation of the entire community-rating regime—defies comprehension. Govt. Severability Br. 36 n.15. The rest of its response is devoted to showing that the *total cost* of subsidies would not increase absent the mandate and insurance regulations, *id.* 36, but that misses the point. Without the insurance regulations, calculating subsidies based on *individual* premiums would, absurdly, *pay* insurers, with federal funds, to continue pricing practices that Congress condemned as discriminatory.

2. Notably, *Amicus* agrees with Private Petitioners that eliminating the mandate, guaranteed-issue, and community-rating would "interfere with operation of the new insurance exchanges." Farr Severability Br. 45. Indeed, the "critical feature" of those exchanges was the "greater standardization of health insurance policies" created by the effective end to individual underwriting. *Id.* Without that standardization, Congress' goals in creating the exchanges "would be significantly frustrated." *Id.* 46. Moreover, the federal subsidies are the incentive to participate in the exchanges, and without those subsidies, there will be no mechanism to sustain the exchanges. The Government's only response is that an insurance exchange could still add some value, offering State-created exchanges as

examples. Govt. Severability Br. 37. Maybe so, but such weak exchanges would not accomplish what *this* Congress was trying to achieve.

3. As *Amicus* again agrees and the Government does not dispute, *see* Farr Severability Br. 50, if the exchanges or subsidies are stricken, the employer-responsibility provision—triggered only when an employee obtains a subsidy on an exchange—can no longer "functio[n] independently." *Alaska Airlines*, 480 U.S. at 684. And, regardless, the Government has no answer to the fact that the Act's "shared responsibility for employers" would, absent the individual mandate, not be "shared responsibility" at all. Yet this Court has long recognized that severance is inappropriate if it would *redistribute* "the burden[s] of the [law]" "in a direction which could not have been contemplated." *Pollock*, 158 U.S. at 636-37.

4. On Medicaid, the Government offers no explanation of its own earlier concession that the burdens on the States of expanding that program were intended to be "offset" by other "cost-saving provisions" for the States—such as guaranteed-issue, community-rating, and (supposedly) the mandate, RE 1023-24—all, assumedly, no longer extant. Congress never intended the States to bear the costs of the Medicaid expansion *absent* those countervailing "cost-saving provisions."

5. Likewise, the Government does not address the Act's set of new taxes, fees, and spending cuts. Yet briefs by numerous *amici* confirm that many of these provisions were included as part of economic *quid pro quo* arrangements, in reliance upon revenue and savings that Congress anticipated would accrue

to healthcare providers as a result of the individual mandate. *See, e.g.*, Am. Hosp. Ass'n Severability Br. 8-22 (identifying three specific provisions that Congress included on the premise that the mandate would "offse[t] the loss" of hospital revenues and "allo[w] them to continue serving patients while still making ends meet").

Nor does the Government grapple with the fact that many of these provisions were reluctantly included in the Act as "Revenue Offset Provisions" to satisfy the political constraint of deficit-neutrality. Without the liability of the premium subsidies, Congress surely would not have imposed these politically unpopular measures, such as the nearly $500 billion in Medicare cuts, *see* State Petrs. Severability Br. 15. Because this Court cannot rebalance the books by "blue pencil[ing]" the Act, *FEF*, 130 S. Ct. at 3162, these "defraying" provisions must also be stricken, *Williams*, 278 U.S. at 244.

6. Finally, while showing little interest in the operational difficulties that would be caused by the mandate's invalidation, the Government complains that inseverability would create the "prospect" of "extraordinary disruption" because "many provisions of the Act" are already "in operation." Govt. Severability Br. 29. But the relevant question is whether Congress *originally* "would ... have enacted those provisions independently," *FEF*, 130 S. Ct. at 3161, not whether invalidating them *now* may be disruptive. Severability analysis obviously does not vary depending on the extent to which the vagaries of the pace of judicial review have caused a statute to be implemented or relied upon.

D. The Government Ignores The Evidence That The Act Was A Unique Package Deal

On top of the many operational distortions that eliminating the mandate would cause, evidence from the legislative process confirms that Congress intended the ACA to stand or fall as a unit.

1. The textual evidence is the notable elimination of a standard severability clause. *See Gubiensio-Ortiz v. Kanahele*, 857 F.2d 1245, 1267 (9th Cir. 1988) (treating such removal as probative evidence that statutory provisions meant to "operate together or not at all"). The Government does not dispute that the bill initially passed by the House *included* such a clause, and that the subsequent Senate bill omitted it. Govt. Severability Br. 43.

The Government claims that the eschewal of a severability clause does not matter, because "there already *are* severability provisions" in the Tax Code, the Social Security Act, and ERISA, all of which were amended in certain respects by the ACA. *Id.* But the existence of those clauses proves Petitioners' point. Congress made clear that invalidation of any part of the ACA will not topple pre-existing parts of the Tax Code, Social Security Act, or ERISA—but the same cannot be said for the ACA itself, because Congress, by contrast, did *not* include a severability clause in *that* law. And the contrast belies the Government's reliance on drafting manuals claiming that severability clauses are "unnecessary." For an unnecessary appendage, they are indeed ubiquitous (including in other comprehensive legislation enacted by the very same Congress, *see* Private Petrs. Severability Br. 59).

2. The contextual evidence includes not only the close margins by which the Act passed, but also the unique circumstances that limited the Senate's ability to amend the Act and prevented the House from even considering amendments to the Senate bill. *See id.* 57-61. While the Government urges that "the politics of the Act's passage" be ignored, Govt. Severability Br. 41, this Court has long framed the inquiry as whether Congress would have enacted the valid provisions even if, "while the bill was pending ... a motion to strike out the [invalid] provisions ... prevailed." *Carter*, 298 U.S. at 313; *accord Alaska Airlines*, 480 U.S. at 685 (considering "legislative bargain"). Given the complex, delicate compromise that produced the Act, the conclusion is inescapable that a successful motion to strike the mandate—and, *a fortiori*, the mandate, insurance regulations, and other elements discussed above—would have decisively ended any possibility that Congress would have enacted the ACA's remaining fragments.

CONCLUSION

This Court should hold that the ACA is entirely non-severable from the individual mandate.

Respectfully submitted,

KAREN R. HARNED
NFIB SMALL BUSINESS
LEGAL CENTER
1201 F St. NW, Suite 200
Washington, DC 20004

PROF. RANDY E. BARNETT
GEORGETOWN UNIV.
LAW CENTER
600 New Jersey Ave. NW
Washington, DC 20001

MICHAEL A. CARVIN
Counsel of Record
GREGORY G. KATSAS
C. KEVIN MARSHALL
HASHIM M. MOOPPAN
YAAKOV M. ROTH
JONES DAY
51 Louisiana Ave. NW
Washington, DC 20001
(202) 879-3939
macarvin@jonesday.com

Counsel for Private Petitioners

Dated: March 13, 2012

REPLY
BRIEF

NOS. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, *ET AL.*,

v.

KATHLEEN SEBELIUS, *ET AL.*

STATES OF FLORIDA, *ET AL.*,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*

On Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

REPLY BRIEF FOR STATE PETITIONERS ON SEVERABILITY

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
BLAINE H. WINSHIP
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

March 13, 2012 *(Additional Counsel Listed on Inside Cover)*

GREG ABBOTT
Attorney General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711
(512) 475-0131

ALAN WILSON
Attorney General
of South Carolina
P.O. Box 11549
Columbia, SC 29211

LUTHER STRANGE
Attorney General
of Alabama
501 Washington Avenue
Montgomery, AL 36130

BILL SCHUETTE
Attorney General
of Michigan
P.O. Box 30212
Lansing, MI 48909

ROBERT M. MCKENNA
Attorney General
of Washington
1125 Washington Street S.E.
P.O. Box 40100
Olympia, WA 98504

JON BRUNING
Attorney General
of Nebraska
KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508
(402) 471-2834

MARK L. SHURTLEFF
Attorney General of Utah
Capitol Suite #230
P.O. Box 142320
Salt Lake City, UT 84114

JAMES D. "BUDDY" CALDWELL
Attorney General
of Louisiana
P.O. Box 94005
Baton Rouge, LA 70804

JOHN W. SUTHERS
Attorney General
of Colorado
1525 Sherman Street
Denver, CO 80203

LAWRENCE G. WASDEN
Attorney General of Idaho
P.O. Box 83720
Boise, ID 83720

Thomas W. Corbett, Jr.
Governor
Linda L. Kelly
Attorney General
Commonwealth of
Pennsylvania
16th Floor
Strawberry Square
Harrisburg, PA 17120

Marty J. Jackley
Attorney General
of South Dakota
1302 East Highway 14
Pierre, SD 57501

Gregory F. Zoeller
Attorney General of Indiana
302 West Washington Street
Indianapolis, IN 46204

Samuel S. Olens
Attorney General of Georgia
40 Capitol Square, SW
Atlanta, GA 30334

Joseph Sciarrotta, Jr.
General Counsel
Office of Arizona Governor
Janice K. Brewer
Tom Horne
Attorney General of Arizona
1700 West Washington
Street, 9th Floor
Phoenix, AZ 85007

Wayne Stenehjem
Attorney General
of North Dakota
State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

Brian Sandoval
Governor of Nevada
State Capitol Building
101 North Carson Street
Carson City, NV 89701

Michael C. Geraghty
Attorney General
of Alaska
P.O. Box 110300
Juneau, AK 99811

MICHAEL DEWINE
Attorney General of Ohio
DAVID B. RIVKIN
LEE A. CASEY
Baker & Hostetler LLP
Special Counsel
30 East Broad Street
17th Floor
Columbus, OH 43215

MATTHEW MEAD
Governor of Wyoming
State Capitol
200 West 24th Street
Cheyenne, WY 82002

WILLIAM J. SCHNEIDER
Attorney General of Maine
Six State House Station
Augusta, ME 04333

J.B. VAN HOLLEN
Attorney General of Wisconsin
114 East State Capitol
Madison, WI 53702

MICHAEL B. WALLACE
Counsel for the State of Mississippi by and through Governor
PHIL BRYANT
Wise Carter Child & Caraway, P.A.
P.O. Box 651
Jackson, MS 39205

DEREK SCHMIDT
Attorney General of Kansas
Memorial Hall
120 SW 10th Street
Topeka, KS 66612

TERRY BRANSTAD
Governor of Iowa
107 East Grand Avenue
Des Moines, IA 50319

QUESTION PRESENTED

If the Affordable Care Act's mandate that virtually every individual obtain insurance exceeds Congress' enumerated powers, to what extent (if any) can the mandate be severed from the remainder of the Act?

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REPLY BRIEF

Neither the federal government nor *Amicus* provides any convincing reason why the Affordable Care Act should stand if the individual mandate that was critical to its passage falls. Indeed, their competing visions of whether the core insurance provisions can survive invalidation of the mandate and the consequences for the remainder of the Act of invalidating both only underscore the interrelatedness of the constituent parts of the ACA and the centrality of the mandate. The reality remains that the individual mandate is the Act's key demand-side provision, and much of the balance of the Act aims to provide the supply necessary to ensure the near-universal coverage forced by the mandate and desired by Congress. The remainder involves provisions designed to pay for the costly core provisions and miscellany that no one could confidently predict would have been enacted independently of the ACA and its core components. The individual mandate is not some stand-alone "reform" that can be excised while leaving the balance of the ACA intact.

Moreover, as *Amicus* recognizes, once it is conceded that the guaranteed issue and community rating provisions fall with the mandate, then there is no logical stopping point. There is no reason whatsoever to conclude that a Congress motivated to provide insurance to those who wanted it but could not obtain it (and willing to commandeer those who could obtain it but did not want it) would have enacted the ACA.

At the outset, the Court should reject the federal government's novel and narrow conception of severability as a series of discrete challenges to the Act's remaining provisions, each with its own separate standing requirement. As *Amicus* acknowledges, severability is a remedial inquiry that follows from a Court's conclusion that a party with standing to challenge a statutory provision has successfully demonstrated the provision's unconstitutionality. It is not a separate challenge to the other provisions of the Act that requires separate standing. So long as the challenge to the invalidated provision is properly before the Court (which it is here), so, too, is the severability inquiry.

The remedial inquiry focuses not on whether the balance of the Act can function independently (which is a necessary, but hardly sufficient condition) or on whether Congress would have preferred something to nothing, but rather on whether the balance of the Act can function in the *manner* Congress intended. As to that question, the federal government has no real answer. The federal government attempts to deny that Congress' goal was to provide near-universal coverage by ensuring near-universal demand through the mandate and near-universal supply through a series of supply-side initiatives. But Congress' own findings and the federal government's arguments elsewhere belie the effort. Beyond that, the federal government's brief is long on reasons why the Act is *capable* of functioning independently of the mandate, but bereft of arguments showing that the Act will function in the manner that Congress *intended* without it. And the federal government simply ignores the consequences of its concession that the guaranteed issue and community rating provisions must fall with the mandate, even though that concession effectively seals the fate of the rest of the Act.

Amicus, for his part, does not dispute that core provisions of the ACA are inextricably intertwined. He instead emphasizes that the guarantee issue and community rating provisions—even more than the mandate—are at the heart of the Act and integral to the functioning of the balance of the Act. But *Amicus*' contention only bolsters the States' argument that the whole Act must fall, as *Amicus* fails to demonstrate that the two insurance regulations can survive without the mandate. Congress itself declared the mandate "essential" to their intended operation, and Congress lacked the political support to enact them without the mandate.

In the end, neither the federal government nor *Amicus* demonstrates that Congress would have enacted the ACA without the mandate, let alone without the mandate and the two insurance provisions that drove the legislative effort. The Court should not rescue provisions of an Act that never would have become law without the lynchpins that held the Act together. Accordingly, the Court should hold the Act invalid in its entirety.

ARGUMENT

I. The Court Can And Should Consider Whether The Mandate Is Severable.

As the States explained in their opening severability brief, *see* States' Br. 27–34, there is no separate standing requirement that must be satisfied before the Court may consider whether the individual mandate is severable from the balance of the Act. Although the federal government continues to insist otherwise, it cannot identify a single case that supports its cause. The closest it comes is *Printz v. United States*, 521 U.S. 898 (1997), but *Printz* is readily distinguishable. *Printz* said nothing about Article III or standing, but instead simply "decline[d] to speculate" whether an invalid provision was severable from discrete provisions of a statute in the absence of a party with an interest in the question. *Id.* at 935. The Court has never cited *Printz* or any other decision as establishing the novel and narrow conception of its severability power that the federal government envisions.

Moreover, the federal government's argument is irreconcilable with *United States v. Booker*, 543 U.S. 220 (2005), the very case that it offers up as establishing the definitive severability inquiry. *See* Govt.'s Br. 27. Setting aside the fact that *Booker*'s three-part severability inquiry makes no mention of standing or the federal government's other prudential concerns, its substantive result cannot be squared with the notion that the severability power may be exercised only as "necessary to remedy an injury to a party before the Court." Govt.'s Br. 20.

Booker involved an as-applied challenge to the Sentencing Guidelines. The Court easily could have remedied the injury at hand with a limited ruling that the Guidelines were unconstitutional as applied to the individuals before it, which is precisely what the federal government requested. *United States v. Booker*, No. 04-104, Br. for United States 43–44. Yet the Court did not stop at holding the Guidelines invalid in the circumstances implicated by the defendants before the Court, but instead went on to conclude that they could not be applied to *any* individuals, *even when their application was concededly constitutional*. *Booker*, 543 U.S. at 266–67. The Court did so because it concluded that the Guidelines would no longer "further Congress' basic objective" if they were mandatory as to some individuals but not others. *Id.* at 267. In other words, the Court employed its severability power to craft the remedy that it believed would best reflect *Congress'* intent, even though it went far beyond what was "necessary to remedy [the] injury to [the] part[ies] before the court." Govt.'s Br. 20.

That the Court never attempted to reconcile that remedial holding with *Printz* (or that *Printz*'s author, who was otherwise dissatisfied with the severability analysis in *Booker*, did not offer a *Printz*-based objection) is reason enough to conclude that *Printz* does not say what the federal government thinks it says. Indeed, even the dissenting Justices in *Booker* described "cases in which an invalid provision or application cannot be severed from the remainder of the statute" as a recognized "exception" to the general rule that the Court "is traditionally limited to issues presented in the case or controversy before the Court, and to the imposition of remedies that redress specific constitutional violations." *Booker*, 543 U.S. at 274 (Stevens, J., dissenting in part).

The incoherence of the federal government's alternative version of severability is clear from its arguments in this case. The federal government (erroneously) insists the States lack standing either to challenge the mandate directly or to seek invalidation of other provisions of the Act that unquestionably injure them on the theory that the mandate is unconstitutional and inseverable. *See* Govt.'s AIA Reply Br. 17–18. Yet it concedes that the States *would* have standing to proceed on the latter theory, seeking the same remedy for the same injury, after some *other* party successfully challenges the mandate. *See* Govt.'s Br. 24. Indeed, the federal government suggests that the States may lurk in the background of *this* case and spring forward to pursue severability if Private Petitioners' challenge to the mandate is successful. *Id.* That makes no sense.

To confuse matters further, the federal government suggests that although this Court's invalidation of the mandate in response to Private Petitioners' challenge would eliminate the standing obstacle, this Court should still exercise its discretion not to reach severability questions "as a matter of prudence and judicial restraint." Govt.'s Br. 25.[1] That makes no sense even under the federal government's own novel theory. At that point, the States would be situated identically to a party that the federal government concedes could challenge the same provisions on severability grounds in a separate challenge. Indeed, the States could bring suit making the exact same severability argument the very next day. The federal government is silent as to how it would serve judicial economy or the adversarial process—or the very strong public interest in resolving the severability question sooner rather than later, *see Amicus* Br. 23—to force the States to start all over again when by the federal government's own telling there is no defect in the case before the Court.[2]

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[1] Of course, *this* Court may always decline to reach an issue (as it did in *Printz*), but the federal government's arguments are not grounded in the discretion unique to this Court. It instead argues that *every* court could (and should) decline to reach severability in these circumstances, and that the Court of Appeals erred by failing to do so. *See* Govt.'s Br. 55 (asking Court to vacate Court of Appeals' severability analysis).

In all events, the federal government concedes that the States have standing to raise severability as to at least some pieces of the ACA, which only underscores that its real complaint is not about the Court's *power* to reach severability, but about the substantive nature of the severability inquiry. Even though the federal government acknowledges that the States satisfy its standing test in part, it maintains the Court still cannot consider whether the mandate is inseverable from the Act as a whole, but must confine itself to deciding whether the mandate is inseverable only from whichever discrete provisions the States have standing to challenge. But severability analysis does not work that way. Once a provision of an Act is invalidated, the question is not whether some other discrete provision of the statute can survive, but whether the balance of the Act can operate in the manner Congress intended. This would be obvious in the case of a law that included a non-severability clause. The entire balance of the Act would fall because that is the result most consistent with Congress' intent. The same result follows here. Petitioners have standing to challenge the mandate and are affected by other provisions of the ACA, and those provisions and the balance of the ACA cannot survive the mandate's invalidation because total invalidation is the result that reflects Congress' intent.

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[2] Moreover, the federal government offers no satisfying answer as to *how* it envisions parties bringing separate follow-on "severability challenges" to each and every other provision of the ACA, as it would seem to require. It identifies no cause of action for bringing a "non-severability" or "legislative intent" challenge to an otherwise valid provision, but simply suggests severability might be raised in administrative proceedings if they exist, or as a defense if and when an enforcement action arises. It then maintains the Court need not be concerned about the issue *here* because the federal government is already "on record conceding the[] inseverability" of certain provisions. Govt.'s Br. 22. But even assuming its concession as to *two* of the ACA's several hundred provisions were reassuring, the federal government will have no reason to make such concessions in future cases if the Court adopts its position.

II. The Individual Mandate Cannot Be Severed From The Balance Of The ACA.

Neither the federal government nor *Amicus* provides any persuasive reason why the ACA should stand if the individual mandate falls. Indeed, their competing visions only reinforce the difficulty with allowing the periphery of the Act to survive the invalidation of the core. Although the federal government largely ignores the consequences of its own severability position, its concession that the guaranteed issue and community rating provisions cannot survive without the mandate effectively dooms the rest of the Act. *Amicus* seems to recognize as much, which is why he emphasizes the centrality of the insurance reforms to the rest of the Act and attempts to separate them from the mandate. But *Amicus*' argument that Congress *could* have wanted guaranteed issue and community rating even without the mandate cannot overcome Congress' own findings to the contrary. Accordingly, the invalidation of the mandate brings down the guaranteed issue and community rating regulations, and the balance of the Act cannot survive without those core provisions.

A. Congress Intended the ACA to Stand or Fall with the Mandate.

As the States illustrated in their opening brief, *see* States' Br. 4–17, the ACA is a delicate balance of inextricably intertwined provisions intended to increase both the demand for and supply of insurance to meet at the point of near-universal coverage. Through the mandate, the Act artificially increases demand by forcing nearly every individual to obtain insurance. The Act then artificially increases supply by mandating that insurers, employers, and States provide insurance to discrete segments of the uninsured population. Because neither the demand side nor the supply side can achieve Congress' overall goal—near-universal coverage—without the other, the Act cannot "function in a *manner* consistent with the intent of Congress," *Alaska Airlines v. Brock*, 480 U.S. 678, 685 (1987), if any of its core provisions is removed. And because the rest of the Act is designed largely to offset or support its core provisions, "the statute created in [their] absence is legislation that Congress would not have enacted." *Id.*

Rather than respond to the substance of that argument, the federal government insists the supply-meets-demand conception is a "rhetorical" device that "bears no relation to what Congress was actually doing [in] the Affordable Care Act." Govt.'s

Br. 33. But the supply-meets-demand model is not some convenient construct conjured up by the States. It is how Congress itself described the ACA: "The [individual mandate], together with the other provisions of the Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured." ACA § 1501(a)(2)(C). Through those combined efforts, Congress intended the Act to "achieve[] near-universal coverage." ACA § 1501(a)(2)(D).

Nor is this view of the ACA shared only by Congress and the States. The federal government has described the Act in the same manner, insisting that "individuals whose conduct is regulated by the minimum coverage provision ... are unable to obtain [insurance] without the insurance market reforms, tax credits, cost-sharing, and Medicaid eligibility expansion that the Act will provide." Mem. Supp. Govt.'s Mot. Summ. J. 1–2 [R.E. 984–85]; *see also* States' Br. 17–18. And it is the federal government that has maintained the Act is a delicate fiscal balance, arguing that Congress "was careful to ensure that any increased spending ... was offset by other revenue-raising and cost-saving provisions." Mem. Supp. Govt.'s Mot. Summ. J. 41 [R.E. 1024].

Indeed, even before this Court, the federal government continues to rely on the interrelatedness of the Act's core provisions to support its constitutional arguments. For example, it (erroneously) contends that forcing a costly Medicaid expansion upon the States is constitutional because their increased Medicaid spending will be "offset by other savings

States will achieve as a result of the Affordable Care Act's reforms." Govt.'s Medicaid Br. 11; *see also* Govt.'s AIA Reply Br. 16 n.7 (same). And it (again, erroneously) argues that the mandate and insurance regulations are necessary and proper because other core components such as the exchanges and the employer mandates "would be less effective" without them. Govt.'s Minimum Coverage Br. 31. In short, it is the federal government's belated attempt to convert the ACA into a series of "stand-alone provision[s]" designed to "independently advance[]" Congress' objectives that "bears no relation to what Congress was actually doing." Govt.'s Br. 33.

More fundamentally, the federal government's argument that Congress would have been satisfied with any one of the Act's many pieces operating independently of the others cannot be squared with its own position on severability. That is because the federal government simply ignores the consequences of its concession that the guaranteed issue and community rating provisions must fall with the mandate. But as the States have explained, *see* States' Br. 47–49, and *Amicus* aptly illustrates, *see Amicus* Br. 45–46, that concession undermines any effort to save the balance of the Act. The individual mandate is integral to the Act as a whole both because it is fully one-half of the demand-supply relationship and because the federal government recognizes its interconnection with the guaranteed issue and community rating provisions. Those latter two insurance regulations are integral for a different reason—they were the principal motivation for the enactment of the ACA. Forcing people who could buy insurance but did not want insurance to buy it anyways (*i.e.*, the mandate) was a means to an end. But making insurance available to those who wanted it but could not buy it was an end itself. Indeed, for many it was the principal reason to vote for the Act. *See* States' Br. 47–50. Thus, as *Amicus* recognizes, the two insurance regulations were "a primary objective of the Act," as they "were regarded as the principal means of bringing new insureds into an otherwise risk-based insurance market." *Amicus* Br. 6, 28. Without them, the ACA would not have become law at all, as it would have provided no solution to the basic problem Congress sought to address: that "millions of people ... had been unable to acquire affordable coverage because of their poor health." *Amicus* Br. 5.

That conclusion is underscored by the fact that "the effects of invalidating th[ose] provisions could not easily be limited." *Amicus* Br. 46. For example, the exchanges were "unquestionably an important objective of federal health care reform." *Amicus* Br. 45. Yet eliminating the insurance regulations would "significantly frustrate[]" their intended operation because the low-income individuals and small businesses that the exchanges are intended to serve would no longer have access to standardized insurance products that are not actuarially priced, "thus undermining much of what Congress hoped to achieve" through the exchanges. *Amicus* Br. 37, 46. Indeed, even the federal government is forced to acknowledge (with considerable understatement) that "the exchanges would not promote competition and lower costs as effectively without guaranteed-issue and community-rating rules." Govt.'s Br. 37.

The same is true of the employer regulations—eliminating the mandate, the insurance regulations, *and* the exchanges would undermine entirely their intended operation because their requirements and penalties are tied directly to the availability of non-actuarially priced insurance on the exchanges. *See, e.g.*, ACA §§ 1512 (requiring employers to inform employees of exchanges), 1513 (penalizing employers if they do not offer adequate insurance and an employee obtains it on an exchange). That is why *Amicus* maintains the employer regulations "can operate effectively" without the mandate, but *only* "provided that the guaranteed issue and community rating provisions (and the exchanges) remain in place." *Amicus* Br. 50.

The federal government contends the exchanges and employer regulations nonetheless may stand because comparable provisions are functioning in other jurisdictions without a mandate or analogous insurance regulations. *See* Govt.'s Br. 35–40. But as already explained, *see* States' Br. 37–38, independent functionality is a necessary but not sufficient condition to establish severability. "The more relevant inquiry ... is whether the statute will function in a *manner* consistent with the intent of Congress." *Brock*, 480 U.S. at 685. That some States have exchanges or employer regulations without a mandate is thus of little value unless those provisions are operating consistently with *Congress'* intent. The federal government makes no attempt to demonstrate that they are. *See* Govt.'s Br. 35–37. To the contrary, the shortcomings of those States' approaches is precisely what led Congress to adopt a more comprehensive approach in the ACA. And the federal government implicitly recognizes the limits of its own comparisons when it comes to the guaranteed issue and community rating provisions. Although some States have retained comparable regulations without an individual mandate, *see Amicus* Br. 44, the federal government readily and correctly rejects *Amicus'* argument that the independent functionality of those state provision is sufficient to render the mandate severable from the ACA's two regulations.[3]

For the same reason, the federal government gets nowhere by arguing that Congress has expanded Medicaid in the past without an individual mandate. To be sure, the Medicaid expansion *can* function independently of the mandate. But, once again, it would not function in the manner that Congress intended. That is because Congress did not just expand Medicaid, but fundamentally transformed it so that it could supply the very insurance coverage that the mandate forces low-income individuals to obtain. Indeed, Congress connected the dots by making clear that Medicaid coverage satisfies the mandate. ACA § 1501(b), 26 U.S.C.A. § 5000A(f)(1)(A)(ii). Needless to say, that specific provision linking the Medicaid expansion to the mandate would not survive the latter's invalidation. Nor would the rest of the Medicaid expansion if congressional intent is to guide the severability analysis.

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[3] Moreover, that States have been reluctant to enact individual mandates to accompany their own health insurance reforms may just reflect the fact that governments closer to the people are more sensitive to the liberty incursion of such a mandate.

Moreover, the federal government makes no real attempt (in either its severability or its Medicaid brief) to deal with the consequences for the balance of the Act if the Court holds both the mandate *and* the Medicaid expansion unconstitutional. Eliminating the mandate, the two insurance regulations, *and* the Medicaid expansion would gut the ACA's projected insurance increase by more than 80%, from 32 million down to as low as 6 million individuals, if not lower. *See* Letter from Douglas Elmendorf, Director, Cong. Budget Office (CBO), to the Hon. Nancy Pelosi, Speaker, U.S. House of Reps. 9 (Mar. 20, 2010) (estimating that 16 million of projected 32 million increase would come from Medicaid expansion); *see also* CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010) (estimating that, without mandate, 5 million fewer would purchase insurance, 6–7 million fewer would enroll in Medicaid, and 4–5 million fewer would obtain employer-sponsored insurance). And at that point, the Act would cease to provide *any* insurance option to the two main groups whose needs Congress sought to address: the low-income and those with pre-existing conditions. The federal government does not even attempt to explain how an ACA that achieves only a small fraction of what Congress set out to accomplish can still "function in a *manner* consistent with the intent of Congress." *Brock*, 480 U.S. at 685.

The federal government alternatively claims Congress must have intended the mandate to be severable because some of the Act's provisions have taken effect in advance of the mandate. Govt.'s Br. 29. Once again, that at most establishes only independent functionality, and not even that as to any of the Act's core provisions, which do not take effect until the mandate becomes operative, further underscoring their interrelatedness. Moreover, some of the provisions with different effective dates are no less tied to the mandate and core insurance provisions because they simply provide transition rules until those core provisions take effect. For example, the temporary high risk health insurance pool program ends when the insurance regulations take effect. ACA § 1101, 42 U.S.C. § 18001; *see also, e.g.*, ACA § 1001, 42 U.S.C. § 300gg-11(a)(2) (phasing in prohibition on annual benefits limits), 42 U.S.C. § 300gg-18(b)(1) (phasing in requirement to provide certain value for premiums); ACA § 1421, I.R.C. § 45R(d)(3)(B) (phasing in new terms for small business tax credits); ACA §2001(a)(4) (temporary benefits to States willing to implement Medicaid expansion ahead of schedule). Those transitional rules can hardly function as Congress intended if the transition will not occur. The same is true with regard to the various "revenue offset provisions" already in effect. *See, e.g.*, ACA §§ 9003–08. Congress would not have put those provisions in place had it known the massive spending on the exchanges and the Medicaid expansion that they are generating revenue to offset would not occur.

Finally, the federal government gains nothing from noting that though the ACA has no severability clause, *other* statutes it amends do. *See* Govt.'s Br. 43. Whether provisions of the ACA are severable from the pre-existing statutory schemes that they amend says nothing about whether they are severable from *the ACA*. If anything, the fact that

Congress legislated against a "background" of statutes that *do* contain severability clauses, *id.*, is all the more reason to conclude that Congress acted deliberately when it omitted the severability clause included in earlier versions of the Act, particularly given that "Congress fully anticipated legal challenges to the constitutionality of" the mandate. *Amicus* Br. 29.

In sum, all of the federal government's efforts to convince the Court to invalidate the two insurance regulations but keep everything else suffer from the same flaw: They fail to demonstrate that those other provisions will "function in a *manner* consistent with the intent of Congress" without the mandate and the core provisions that concededly fall with it, *Brock*, 480 U.S. at 685, and instead demonstrate at most independent functionality and a general tendency to "expand access to health care." Govt.'s Br. 34. Moreover, the federal government does not meaningfully respond to the States' argument that the political impetus behind the ACA was the mandate and the two insurance regulations, meaning both the ability and the desire to enact the ACA would have been lacking had Congress known those key provisions would not survive. As those political realities and the undeniably integrated relationships at the core of the Act confirm, the ACA without its key provisions "is legislation that Congress would not have enacted." *Brock*, 480 U.S. at 685.

B. The Mandate Cannot Be Severed from the Core Insurance Regulations.

Unlike the federal government, *Amicus* does not deny the interrelatedness of core provisions of the

ACA, or that some of those provisions cannot function as Congress intended if others are removed. But in *Amicus*' view, it is the guaranteed issue and community rating regulations, not the individual mandate, that are critical to the Act's intended operation. *Amicus* contends that those two provisions can stand without the mandate, and that therefore the rest of the Act can stand as well. *See Amicus* Br. 48. *Amicus*' argument cannot survive its flawed premise.

Amicus first takes issue with the Court's own severability inquiry and its focus on whether the balance of an act can "function in a *manner* consistent with the intent of Congress" once the invalidated provision is removed. *Brock*, 480 U.S. at 685. According to *Amicus*, *Brock* "focus[es] attention on the wrong question" by "inviting a comparison between the judicially modified statute and the statute originally enacted by Congress," instead of asking whether "'the legislature would have preferred what is left of its statute to *no statute at all*.'" *Amicus* Br. 16 (quoting *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006) (emphasis added by *Amicus*)).

But a comparison of the statute with and without the invalid provision is inevitable, and the resulting inquiry into congressional intent is not simply a question of whether Congress would have preferred something to nothing. *Brock* does not ask courts to determine whether legislation will function in the *exact same* manner without the invalidated provision—if it did, the answer would always be no. But *Brock* and any other severability analysis worthy of the name necessarily require some comparison between the original legislation and the balance of the act and an inquiry into whether the balance will continue to function as Congress intended. That is why courts must consider factors such as the invalid provision's "importance ... in the original legislative bargain," *Brock*, 480 U.S. at 685, and its role "in the context of Congress'" broader legislative goals, *INS v. Chadha*, 462 U.S. 919, 934 (1982).

Amicus seems to suggest that once the challenged provision is invalidated, it simply falls out of the equation, leaving a court to ask only "whether Congress would prefer to go back to" the law as it existed before the new legislation came about. *Amicus* Br. 25. But that is precisely the sort of "tautological" inquiry that *Brock* warned against, as Congress' dissatisfaction with the old law will always be "apparent from the existence of" the new one. *Brock*, 480 U.S. at 685 n.7. Thus, a court must focus not on whether "Congress would have enacted *some* form of" legislation if the only alternative were the status quo, but on whether "the statute created in [the invalidated provision's] absence is legislation that Congress would not have enacted." *Id.*

Here, any notion that Congress would have enacted the insurance regulations without the mandate is readily rebutted by Congress' own findings. Congress could not have been clearer that it considered the mandate "*essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." ACA § 1501(a)(2)(I) (emphasis added). Indeed, Congress explained that the mandate was supposed to serve *two* critical functions with respect to the intended operation of those regulations—to "minimize th[e] adverse selection" they would create and to offset the tremendous costs they would generate by "broaden[ing] the health insurance risk pool to include healthy individuals." *Id.*

Amicus contends the Court should disregard Congress' findings because Congress made them to address its commerce power, not the severability question. But the purpose of the findings cannot alter their content. Indeed, in the absence of a severability or non-severability clause, Congress will rarely, if ever, make express findings about its intent in the event of partial invalidity. Accordingly, courts will almost inevitably examine findings made for some other purpose. Here, the findings provide a direct answer to the question whether Congress believed "the policies [it] sought to advance" through the insurance regulations "can be effectuated" without the mandate. *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (plurality opinion). In contending otherwise, *Amicus* seems to suggest that Congress did not *really* consider the mandate "essential," but only used that label to bolster a weak constitutional argument. *See Amicus* Br. 32–33. But the inquiry into legislative intent demanded by the severability analysis is difficult enough without looking a gift horse in the mouth. If Congress finds one provision "essential" to another, there is no basis for ignoring that finding if one of the provisions happens to be unconstitutional.

Indeed, if anything, Congress' findings are *more* relevant for severability purposes than for constitutional purposes because the severability inquiry focuses solely on Congress' *intentions*, which is precisely what those findings embody.[4] *Amicus* mistakenly suggests the States ask the Court to focus on something quite different, namely, whether, "as a practical matter, guaranteed issue and community rating can[] work in an acceptable way without the countervailing effects of" the mandate. *Amicus* Br. 33. But the States fully agree with *Amicus* that "this kind of predictive factfinding about the interplay of complex economic forces falls more naturally within the scope of legislative, rather than judicial, competence." *Amicus* Br. 34. That is why the Court should not second-guess Congress' judgment that the insurance regulations were too costly—both fiscally and politically—to enact without an individual mandate to subsidize them.

Yet despite his professed disagreement with that kind of "empirical" approach to severability, *Amicus* Br. 6, that is precisely what *Amicus* invites the Court to do. According to *Amicus*, the Court may leave the insurance regulations in place because eliminating the mandate would not be "so calamitous that no rational Congress could favor that limited remedy." *Amicus* Br. 35. But that is not the standard. This Court does not review statutes the way it reviews allegedly inconsistent jury verdicts. The standard is not calamity or whether any rational Congress could pass such a statute, but rather "what the Congress that actually passed the Act" would have wanted. Govt.'s Br. 42. As to that question, even *Amicus* is forced to concede that the insurance regulations "were meant to work together with" the mandate and "likely will operate less ideally without" it. *Amicus* Br. 25; *see also Amicus* Br. 9 ("Congress expected those provisions to work in concert").

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[4] The federal government fails to grasp that distinction between severability and constitutional analysis when it erroneously contends that the States' opening brief concedes that the mandate "is necessary to make effective the Act's guaranteed-issue and community-rating insurance market reforms." Govt.'s Br. 26. As the States explained, *see* States' Br. 38 n.16, that Congress' characterization of the relationship between the mandate and those regulations should be accepted for *severability* purposes does not mean it should be accepted for *constitutional* purposes as well. Simply calling the mandate "essential" does not make it a "law[] necessary and proper for carrying into Execution" the commerce power, U.S. Const. art. I, § 8, cl. 18, particularly given that Congress enacted the mandate to *counteract* the effects of those regulations, not to make those regulations effective. *See* States' Minimum Coverage Br. 33–35.

Moreover, *Amicus* simply ignores the States' argument that the political realities were such that Congress could not have enacted the two insurance provisions without the mandate even had it wanted to do so. As the States explained, *see* States' Br. 13, the Act's proponents secured the critical insurance industry support for those regulations only by promising to include an individual mandate to provide the industry with a multi-billion dollar annual subsidy to offset their costs. Thus, "the importance of the [mandate] in the original legislative bargain" cannot be overstated. *Brock*, 480 U.S. at 685. Severability is not a means by which Congress may use the courts to circumvent accountability constraints on its legislative power. *See Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 636 (1895) (courts may not "substitute for the law intended by the legislature one they may never have been willing, by itself, to enact"). *Amicus* is silent as to why the

Court should leave in place regulations that Congress lacked the support to enact without the promise of the unconstitutional mandate.

Amicus alternatively insists the mandate must be severed "[b]ecause the effects of invalidating the guaranteed issue and community rating provisions could not easily be limited" given their integral relationship to other core provisions. *Amicus* Br. 46. *Amicus*' argument that the *rest* of the Act could not function as Congress intended without those regulations makes a convincing case for *total* invalidation of the ACA. *See supra*, pp. 12–13. But it provides no basis for concluding that Congress believed the insurance regulations could operate in the manner it intended without the mandate. Rather, it underscores that the mandate and the inextricably interrelated guaranteed issue and community rating regulations are at the very heart of the entire Act. Congress' own findings make clear that it did not intend to have one without the other, and without those core provisions "it is evident that the Legislature would not have enacted" the balance of the ACA. *Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932). Accordingly, both those regulations and the rest of the Act must fall with the mandate.

CONCLUSION

The Court should hold the ACA invalid in its entirety.

Respectfully submitted,

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508

GREG ABBOTT
Attorney General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711

March 13, 2012 *Counsel for State Petitioners*

REPLY
BRIEF

Nos. 11-393 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.

STATE OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

REPLY BRIEF FOR THE RESPONDENTS
(Severability)

DONALD B. VERRILLI, JR.
Solicitor General
Counsel of Record
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

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REPLY BRIEF FOR THE RESPONDENTS
(Severability)

Because the minimum coverage provision of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act or Act)[1] is a constitutional exercise of Congress's powers, this Court need not consider any issue of severability in this case. If the Court does have occasion to address severability, however, it should decline to invalidate as inseverable the many provisions of the Act that do not apply to petitioners, much less to take the extraordinary step of nullifying the entire statute. If the Court does address severability, it should find only the guaranteed-issue and community-rating provisions inseverable and allow the rest of the Act to stand.

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[1] Amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

I. THE SEVERABILITY OF MOST PROVISIONS OF THE ACT MAY NOT BE CONSIDERED IN THIS CASE

The government demonstrated in its opening brief (at 14-25) that, with the limited exception of state petitioners' meritless inseverability contention regarding the Act's expansion of Medicaid eligibility, petitioners' severability arguments are not properly presented in this case. In addition to statutory bars to review relevant to many parts of the Act and general limitations on the scope of equitable relief, see *id.* at 14-16 & nn.8 & 9, 23, courts have "no business" addressing the severability of provisions that "burden only" parties absent from the litigation. *Printz* v. *United States*, 521 U.S. 898, 935 (1997) (declining "to speculate regarding the rights and obligations of parties not before the Court").

A. The Court-appointed amicus curiae contends that the Court may address the purported inseverability of the remaining provisions of the Act that do not apply to petitioners (including guaranteed issue and community rating) because severability involves "the proper scope of equitable relief for the constitutional violation that the plaintiffs have already established." Br. 20. Amicus's premise that severability is a form of "relief" is correct, but amicus draws the wrong conclusion from that premise.[2] The Court has "insisted * * * that 'a plaintiff must demonstrate standing separately for each form of relief sought.'" *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 352 (2006) (quoting *Friends of the Earth, Inc.* v. *Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 185 (2000)). Indeed, it was the *dissenters* in *City of Los Angeles* v. *Lyons*, 461 U.S. 95 (1983), who submitted that, once a plaintiff's standing to assert a claim is established, "his requests for particular forms of relief [do not] raise any additional issues concerning his standing." *Id.* at 114 (Marshall, J., dissenting). The majority, however, squarely rejected that position, holding that a plaintiff who unquestionably had standing to assert a constitutional violation and seek damages did not have standing to secure an injunction. *Id.* at 109.

Amicus is correct that a court "must examine how various remedies might affect the public interest" when exercising its equitable powers. Br. 20. The public interest requirement, however, does not expand the courts' equitable authority; it instead limits that authority. Courts must consider whether "the public interest would * * * be *disserved*" by an equitable remedy that might otherwise be warranted. *Monsanto Co.* v. *Geertson Seed Farms*, 130 S. Ct. 2743, 2756 (2010) (emphasis added) (citation omitted); see, *e.g.*, *Winter* v. *NRDC*, 555 U.S. 7, 24, 26, 32-33 (2008). The obligation to consider the public interest when crafting an equitable remedy does not justify expanding relief beyond what is necessary to redress the injury to the plaintiff actually before the court. Cf. *United States* v. *National Treasury Employees Union*, 513 U.S. 454, 478

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[2] Amicus does not mention the statutes that would preclude invalidation of a number of provisions, such as the Act's tax and Medicare provisions, on inseverability or any other grounds. Gov't Br. 14-15 nn.8 & 9.

(1995). In *Lyons*, for example, the Court recognized that there was a public interest in stopping "certain practices of law enforcement officers [that] are unconstitutional," but it nonetheless held that a "federal court * * * is not the proper forum to press such claims unless the requirements for entry and the prerequisites for injunctive relief are satisfied." 461 U.S. at 111-112.

B. While amicus maintains that the Court has authority to invalidate as inseverable provisions of the Act that do not apply to petitioners, amicus acknowledges that "the Court is not *required* to decide the severability issues that petitioners raise." Br. 22. Amicus also agrees that any severability questions left undecided by the Court could be addressed in subsequent litigation by parties with an actual stake in their continuing validity. *Id.* at 23 n.5; see Gov't Br. 21-22.[3] Amicus nonetheless maintains that the Court should address petitioners' inseverability claims in this case in the event it invalidates the minimum coverage provision. Br. 23.

Amicus observes that declining to address petitioners' inseverability arguments in this case would delay resolution of the status of the remainder of the Act. Br. 23. But any period of uncertainty would presumably be quite brief, and amicus does not address the countervailing costs associated with premature adjudication. This Court has emphasized the importance of having legal questions "resolved * * * in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action." *Massachu-*

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[3] In a hypothetical situation in which Congress "included an express inseverability clause" in a statute (Court-Appointed Amicus Br. 21 n.4), such follow-on litigation would be quickly completed, or might not even be necessary in the first place, because the Executive could choose not to enforce the remaining provisions of such a statute in light of Congress's express instructions on the question.

setts v. *EPA*, 549 U.S. 497, 517 (2007) (quoting *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 581 (1992) (Kennedy, J., concurring in part and concurring in the judgment)). The Court "depends for illumination" on "concrete adverseness" to "sharpen[] the presentation of issues." *Ibid.* (quoting *Baker* v. *Carr*, 369 U.S. 186, 204 (1962)). Such concrete adverseness is wholly lacking here with respect to nearly the entire Act. Gov't Br. 18-19. Petitioners have not even offered a reason why they are so vigorously seeking invalidation of the myriad provisions of the Act that do not apply to them (or that *benefit* their members or citizens, see *id.* at 19), much less established any cognizable harm flowing from those provisions.[4] The absence of a properly adversarial presentation more than offsets any momentary benefit that would be gained by deciding severability issues in the wholly abstract context of this case.[5]

II. IF THE COURT REACHES THE QUESTION, IT SHOULD HOLD THAT THE ACT IS SEVERABLE FROM THE MINIMUM COVERAGE PROVISION EXCEPT FOR THE GUARANTEED-ISSUE AND COMMUNITY-RATING PROVISIONS THAT TAKE EFFECT IN 2014

If the Court does address severability questions in this case, it should reject petitioners' contention that the entire Act must be invalidated, as the Court-appointed amicus persuasively demonstrates. Br. 48-52. The Court should, however, reject amicus's contention that the Act's guaranteed-issue and community-rating provisions are severable from the minimum coverage provision. *Id.* at 24-47.

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[4] Any attempt by petitioners to establish injury from other provisions of the Act for the first time in this Court would come too late. Cf. *Summers* v. *Earth Island Inst.*, 555 U.S. 488, 495 n.* (2009).

[5] While state petitioners do have a concrete interest in the expansion of Medicaid eligibility, the Court is not required to address that issue if it agrees with individual petitioners that the minimum coverage provision is unconstitutional. Gov't Br. 24-25. In any event, the claim that the expansion is inseverable from the minimum coverage provision lacks merit. *Id.* at 34-35; Court-Appointed Amicus Br. 48-50; California Amicus Br. 16-17; see also Gov't Medicaid Br. 52-53.

A. As the Court-appointed amicus explains, "[i]t is a striking use of judicial power for a federal court to declare that perfectly valid provisions of a law passed by Congress are void and unenforceable." Br. 8. "Before taking such action, therefore, the Court should have clear evidence that Congress, faced with the unconstitutionality of one part of a statute, would have wanted some or all of the remaining parts struck down as well." *Ibid.* As the government demonstrated in its opening brief (at 28-44), petitioners have failed to satisfy this standard with respect to virtually the entire Act (much of which is already in effect). "Compared to the guaranteed issue and community rating requirements, the remainder of the Act has far less connection to the minimum coverage provision—in many instances, none whatsoever." Court-Appointed Amicus Br. 48. Indeed, "petitioners have made little attempt to demonstrate that the Act in general, or specific provisions in particular, cannot function in an effective manner without the minimum coverage provision alone." *Ibid.*

Many of the Act's provisions, like the minimum coverage provision, are intended to expand access to affordable health care. That common purpose is a reason to find the provisions severable, not to invalidate them. See *United States* v. *Booker*, 543 U.S. 220, 258-259 (2005) (Courts should preserve provisions that are "consistent with Congress' basic objectives in enacting the statute."); *New York* v. *United States*, 505 U.S. 144, 186 (1992) ("Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated."); see also *Leavitt* v. *Jane L.*, 518 U.S. 137, 143-144 (1996) (per curiam) ("The relevant question * * * is not whether the legislature would prefer (A+B) to B, because by reason of the invalidation of A that choice is no longer available. The relevant question is whether the legislature would prefer not to have B if it could not have A as well."). Among the provisions that are severable for this basic reason are the expansion of Medicaid eligibility, see note 5, *supra*; the employer responsibility provision and small-business tax credits, Court-Appointed Amicus Br. 50-51; Gov't Br. 35; the health-insurance exchanges, Gov't Br. 36-37; California Amicus Br. 14-16; the premium tax credits, Gov't Br. 36; and the Act's insurance reforms beyond guaranteed issue and community rating, *id.* at 38-40.

In addition, there is no basis for invalidating as inseverable provisions of the Act "that have no apparent connection at all, let alone an inextricably close connection, to the minimum coverage provision." Court-Appointed Amicus Br. 51-52; see Gov't Br. 30-31. Congress surely would not have intended such stand-alone provisions, passed as part of a large omnibus bill, to fall in the event the minimum coverage provision were invalidated.[6]

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[6] See California Amicus Br. 9-10 & n.3 (noting that many parts of the Act "were originally introduced as entirely separate bills that did not even conceive of the minimum coverage provision"); National Indian Health Bd. Amicus Br. 4-5 (Affordable Care Act's amendments to the Indian Health Care Improvement Act, 25 U.S.C. 1601 *et seq.*, "were developed over a period of ten years in a separate legislative process from the ACA" and "are not connected to or dependent on the application of minimum coverage"); American Pub. Health Ass'n Amicus Br. 19-24 (discussing "stand-alone" measures in the Act intended to "guide public health research and infrastructure development"); AARP Amicus Br. 15-24 (describing series of Medicare reforms in the Act,

B. The Court-appointed amicus is correct that Congress's decision to extend to the individual insurance market guaranteed-issue and community-rating protections like those that previously applied only in the group markets, see Gov't Minimum Coverage Br. 5-6, 28-29, is a central component of the Act's effort to remove barriers to access and make coverage more affordable. Br. 25-28; American Ass'n of People with Disabilities Minimum Coverage Amicus Br. 26-32. Contrary to amicus's submission, however, there is clear evidence that Congress would *not* have wanted those provisions to stand without the minimum coverage provision.

Amicus is also correct that the provisions were "meant to work together." Br. 25. In fact, Congress viewed the minimum coverage provision as essential to the success of guaranteed issue and community rating, and it understood that, without a minimum coverage provision, those measures would increase insurance costs and reduce access to coverage—the opposite of what Congress intended in enacting the Affordable Care Act. Those most familiar with the workings of the insurance industry have informed the Court that they hold the same view. See America's Health Ins. Plans (AHIP) Amicus Br. 4, 11 (health insurers with "extensive, first-hand, and on-the-ground experience with health insurance markets" explain that guaranteed issue and community rating without minimum coverage provision

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including elimination of the Medicare prescription drug benefit "donut hole" that was the "culmination of extensive efforts by Congress" over a number of years); Joella Swann Amicus Br. 15 (noting that the Act includes "an entirely discrete" provision amending a provision of the Black Lung Benefits Act, 30 U.S.C. 901 *et seq.*, governing eligibility for survivor benefits, see Gov't Br. 31); 11-398 Pet. App. 174a (discussing provision in the Act "establishing reasonable break times for nursing mothers").

would "deliver[] the opposite of what Congress intended by ensuring that there would not be 'affordable care' under the Affordable Care Act"); American Acad. of Actuaries Amicus Br. 3-4 ("In the Academy's view, a decision invalidating the individual-mandate provision, while leaving in place the 'guaranteed-issue' and 'community-rating' provisions, would have adverse effects on the affordability and accessibility of health insurance in the United States.") (footnote omitted).

1. Congress's findings expressly make the connection between the minimum coverage provision on the one hand and guaranteed issue and community rating on the other. Congress found that, without a minimum coverage provision, "many individuals" in a guaranteed-issue/community-rating market "would wait to purchase health insurance until they needed care." 42 U.S.C.A. 18091(a)(2)(I);[7] see Gov't Br. 45 n.21. Congress further found that the minimum coverage provision would "minimize" such adverse selection and was therefore "*essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C.A. 18091(a)(2)(I) (emphasis added). Given that Congress viewed the minimum coverage provision as "essential" to the success of a reformed individual insurance market with guaranteed issue and community rating, it would not have wanted those provisions to stand without that "essential" supporting component. Gov't Br. 45-47.

The Court-appointed amicus describes this inseverability argument based on Congress's findings as "perfectly reasonable." Br. 31. Amicus observes, however, that "the findings were not addressed to the issue of severability" but instead were included "to show the close relationship between the minimum coverage provision and interstate commerce," and thereby to underscore the constitutionality of the provision. *Id.* at 31-32. Amicus is correct that Congress made these findings in order explicitly to demonstrate the constitutionality of the minimum coverage provision. Amicus is also correct to note (*id.* at 32-33) that the question of Article I power is not the same as the question of severability. A provision may be a valid means to make a broader regulation of interstate commerce effective even if the broader scheme without the provision would not defeat Congress's overall goals.

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[7] Unless otherwise noted, all citations hereinafter to the United States Code refer to Supp. IV 2010, and all citations to the United States Code Annotated refer to Supp. 2011.

In this case, however, it is evident that Congress's finding on the "essential" connection between the provisions, 42 U.S.C.A. 18091(a)(2)(I), "though directed at the antecedent constitutional question, can also be read to answer the severability question." Court-Appointed Amicus Br. 33. This is so because the finding rested on evidence showing that, unless paired with a minimum coverage provision, the guaranteed-issue and community-rating provisions would actually undercut Congress's goals because they would cause premiums to rise and coverage to decline. See pp. 10-18, *infra*. As both a logical and practical matter, therefore, Congress's finding on the "essential" role of the minimum coverage provision in effectuating the guaranteed-issue and community-rating provisions effectively serves as an inseverability clause—albeit one limited to only those two provisions, given that Congress did not find the minimum coverage provision to be "essential" to any other part of the Act.

2. Congress's express findings on the essential nature of the minimum coverage provision to guaranteed issue and community rating were based on strong empirical evidence

in the legislative record. During proceedings leading to enactment of the Affordable Care Act, Congress was warned that it should not adopt guaranteed-issue and community-rating insurance reforms unless it paired them with a minimum coverage provision to combat adverse selection. In particular, Uwe E. Reinhardt, one of the country's foremost health-care economists, told Congress that "[i]t is well known that community-rating and guaranteed issue coupled with voluntary insurance, tends to lead to a death spiral of individual insurance." Uwe E. Reinhardt, Princeton Univ., *Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the House Comm. on Energy & Commerce*, 111th Cong., 1st Sess. 11 (Mar. 17, 2009); see pp. 14-16, *infra* (discussing testimony of National Association of Insurance Commissioners).[8]

a. Amicus does not dispute that guaranteed issue and community rating, in isolation from the other reforms in the Act, would seriously exacerbate the problem of adverse selection in the individual insurance market. Indeed, amicus acknowledges that the Congressional Budget Office (CBO)

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[8] See also, *e.g.*, *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the House Comm. on Ways & Means*, 111th Cong., 1st Sess. 9 (2009) (*House Hearing*) (statement of Uwe E. Reinhardt) ("[I]f you put those two mandates on the [insurance] industry," *i.e.*, guaranteed issue and community rating, "you must also mandate the individual to be insured or the market will blow up, as it has in New Jersey" and other States.); *id.* at 117 (statement of Phil Caper, M.D., and Joe Lendvai) ("[W]hen Maine enacted legislation some years ago requiring insurers to accept anybody who applied (guaranteed issue) and charge all policyholders in the same class the same premiums (community rating), most health insurers withdrew from the state.").

> noted just what petitioners and the United States assert: that changes like guaranteed issue and community rating, viewed by themselves, "would make nongroup coverage more attractive to people who are older and who expect to be heavier users of medical care and less attractive to people who are younger and expect to use less medical care."

Br. 36 (quoting CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 19 (Nov. 30, 2009) (*Insurance Premiums*)). CBO concluded that, absent other changes to the insurance market, "people who are older and more likely to use medical care would be more likely to enroll in nongroup plans," and that this adverse selection "would tend to increase premiums in the exchanges relative to nongroup premiums under current law." *Ibid.*

As amicus notes (Br. 36), CBO cited "several" provisions of the version of the Affordable Care Act it had reviewed that "would tend to mitigate that adverse selection." *Insurance Premiums* 19. Most notably, CBO concluded that the bill's minimum coverage provision "would * * * encourage a broad range of people to take up coverage in the exchanges" and thus mitigate adverse selection. *Id.* at 20. CBO also cited other provisions of the legislation that would mitigate adverse selection. For example, CBO noted that the bill would establish an annual open enrollment period for new individual policies sold in exchanges, which would reduce opportunities for healthy people to wait until illness struck before enrolling. *Id.* at 19. CBO also concluded that the substantial premium tax-credit subsidies available in the exchanges would encourage enrollment of a broad range of individuals. *Id.* at 19-20.

But CBO did not assess the relative importance of these provisions in mitigating adverse selection. Nor did it suggest that open enrollment periods and tax credits, by themselves, would be sufficient to mitigate adverse selection in the absence of a minimum coverage provision.[9] Nonetheless, amicus hypothesizes that annual enrollment periods and premium subsidies would in fact be sufficient. From that hypothesis, amicus further posits that Congress would have thought the same, thus intending guaranteed issue and community rating to survive if the minimum coverage provision were held unconstitutional. Br. 36-39. Amicus is incorrect.

As an initial matter, severability is a question of congressional intent, not post-enactment economic modeling. Amicus is correct that "predictive factfinding about the interplay of complex economic forces falls more naturally within the scope of legislative, rather than judicial, competence." Br. 34. That principle, however, cuts in favor of finding the guaranteed-issue and community-rating provisions inseverable. Congress's findings (with ample empirical support) reflect its determination, based on a legislative prediction it is uniquely qualified to make, *Turner Broad.*

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[9] Moreover, CBO's analysis was based on an earlier version of the legislation that capped the shared responsibility payment at $750 per adult and $375 per child. See *Insurance Premiums* 20; see also *id.* at 1 (noting that analysis was of a proposal introduced by Senator Reid on November 18, 2009). The minimum coverage provision was later revised to cap the penalty for many individuals at approximately the price of obtaining insurance. Compare 26 U.S.C. 5000A(c), with 155 Cong. Rec. S11,607, S11,642 (daily ed. Nov. 19, 2009) (minimum coverage provision in earlier version of the legislation analyzed by CBO). That decision to link the penalty to the price of insurance will result in increased economic incentives to obtain coverage, making the minimum coverage provision as enacted even more effective in mitigating adverse selection than the version analyzed by CBO would have been.

Sys., Inc. v. *FCC*, 520 U.S. 180, 195-196 (1997), that the minimum coverage provision was "essential" to the success of the guaranteed-issue and community-rating reforms. It made no comparable finding for annual enrollment periods or premium tax credits.

In any event, amicus is mistaken in suggesting that Congress would have viewed annual enrollment periods and tax credits as sufficient to mitigate adverse selection by themselves. Amicus is correct that, if enrollment periods are limited, uninsured persons who "choose to forego enrollment during the specified period * * * must bear the risk of illness suffered prior to the next enrollment period." Br. 36. But that incentive to obtain insurance will be far less powerful than the incentive the uninsured now have to do so. Under current law, insurers in the individual market can deny coverage to uninsured adults outright or charge unaffordable premiums based on medical conditions. Despite those risks, millions of people postpone the purchase of insurance in the individual market. There is every reason to think that such adverse selection would increase if, instead of facing the risks of permanent denial of coverage and unaffordable premiums, uninsured individuals merely faced the risk of having to wait until the next enrollment period to obtain coverage.

Amicus is likewise mistaken in positing that Congress would have believed that the Act's premium tax credits would sufficiently mitigate adverse selection without a minimum coverage provision. In fact, Congress understood that premium tax credits were necessary, but not sufficient, to protect individual insurance markets operating under guaranteed-issue and community-rating rules. The National Association of Insurance Commissioners (NAIC), "offer[ing] the experience and expertise of the states," specifically warned Congress that "[s]tate regulators [could] support" national guaranteed-issue reforms only "to the extent they [were] coupled with an effective and enforceable individual purchase mandate *and* appropriate income-sensitive subsidies to make coverage affordable." *Roundtable Discussions on Comprehensive Health Care Reform: Hearings Before the Senate Comm. on Finance*, 111th Cong., 1st Sess. 502-503, 504 (2009) (*Roundtable*) (statement of Sandy Praeger, Kansas Commissioner of Insurance, on behalf of NAIC) (emphasis added).[10] NAIC noted that, by themselves, "subsidies or incentives could ameliorate some of the selection issues," but emphasized that "as costs continue to rise and premiums increase, the effectiveness of such inducements could erode." *Id.* at 504. Congress's recognition of NAIC's technical expertise is expressly reflected in various provisions giving the group a formal role in the Act's implementation,[11] so there is every reason to believe that Congress, in light of NAIC's warning, did not intend guaranteed issue and community rating to stand if the minimum coverage provision were held unconstitutional.

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[10] See *Roundtable* 74 (statement of Commissioner Praeger) ("[W]e have a great opportunity here to, I think, get rid of one of the most oner[o]us aspects of the current system, and that is rating based on health. The people who need health insurance are sometimes absolutely just priced out, especially in the individual market. But you cannot do that without requiring that everybody have coverage, otherwise you will just wait until you are sick and then buy the coverage. That is where we do need rules set at the national level so that all of the States are functioning under the same system.") (paragraph break omitted).

[11] Among other things, Congress directed the Secretary of Health and Human Services to consult NAIC in formulating community-rating rules, 42 U.S.C. 300gg(a)(3), and in establishing transitional reinsurance programs to mitigate adverse selection during the transition to a guaranteed-issue/community-rating individual insurance market, see 42 U.S.C.A. 18061(b)(1) and (3)(B)(iii). See also, *e.g.*, 42 U.S.C. 300gg-15, 300gg-18(c), 300gg-19(b)(1); 42 U.S.C.A. 18031(c)(1)(F), 18041(a)(2), 18053(a)(1).

NAIC's recommendation was consistent with CBO's findings on the connection between reductions in premiums through tax credits and increases in participation rates in the individual insurance market. When CBO examined the impact of premium tax credits in isolation, it concluded that a 50% reduction in premiums would lead no more than 20% of the uninsured to obtain coverage, and that the figure could be as low as 4%. *CBO's Health Insurance Simulation Model: A Technical Description* 21 (Oct. 2007). CBO further found that, even if tax credits were to reduce premiums by 70%, the rate of participation in the individual market would still be less than 40%. *Id.* at 22 fig.2. Accordingly, while the Act's premium tax credits (and cost-sharing reductions) are generous, Gov't Minimum Coverage Br. 10-11, Congress understood that it was necessary to pair them with the minimum coverage provision in order to adequately mitigate adverse selection.

The pre-Act experience in Massachusetts confirmed that premium subsidies alone would not prevent adverse selection in the individual market. Amicus is mistaken to suggest that "no State providing for guaranteed issue and community rating bolstered its insurance reforms with subsidies of the particular type and magnitude contemplated by the federal Act." Br. 42. Massachusetts made heavily subsidized insurance available to residents with incomes below 300% of the federal poverty level for nearly a year before that State's minimum coverage provision took effect. Amitabh Chandra et al., *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 New Eng. J. Med. 293 (2011). In Massachusetts, subsidies for eligible individuals are even more generous than those that will be available under the Affordable Care Act. *Id.* at 294, 295.

Nonetheless, the Massachusetts enrollees who signed up for coverage before the state tax penalty took effect (but while the state subsidies were available) were nearly four years older on average than those who signed up after the tax penalty was fully implemented. *Id.* at 294. They were almost 50% more likely to have a chronic illness. *Ibid.* And their health-care costs were about 45% higher than those who signed up after the tax penalty was fully in effect. *Ibid.* In other words, subsidies paired with a minimum coverage provision proved significantly more successful in combating adverse selection in Massachusetts than did subsidies alone.

b. Amicus recognizes (Br. 40-41) that CBO has projected that adverse selection would increase premiums in the individual market by 15%-20% relative to current law if the Act were implemented without the minimum coverage provision. Amicus also acknowledges that another study found that "premiums for individual polices would rise by 27 percent" if the minimum coverage provision were invalidated but guaranteed issue and community rating remained. Br. 41 (citing Jonathan Gruber, *Health Reform Without the Individual Mandate: Replacing the Individual Mandate Would Significantly Erode Coverage Gains and Raise Premiums for Health Care Consumers* 2 (Feb. 2011)).[12]

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[12] The two additional studies cited by amicus do not provide substantial support for the position amicus advances. The lower Urban Institute estimates that amicus cites (Br. 38) assumed "robust enrollment in subsidized coverage." Matthew Buettgens & Caitlin Carroll, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care* 2 (Jan. 2012). By contrast, when it modeled the expected premium increase if the take-up of subsidized coverage were low, it concluded that premiums for policies sold through the exchanges would rise by 25%. *Id.* at 6, tbl. 4. The Urban Institute also cautioned that "[t]here is a genuine risk that initial low exchange enrollment could

Amicus suggests that these predictions of significant premium increases (and resulting decline in participation) in the individual market "fall short of demonstrating that the health insurance market will be so negatively impacted that Congress would plainly prefer a return to a market without guaranteed issue and community rating." Br. 41. But Congress's goal was to make coverage more accessible and affordable, not to strike a balance at some particular level of "negative[] impact[]." *Ibid.* The individual insurance market is already plagued by high premiums and low participation, and there is no reason to conclude that Congress would have wanted to implement measures that would cause that market to deteriorate further.

c. As the government explained in its opening brief (at 47-50), a number of States attempted to implement guaranteed issue and community rating without a minimum coverage provision, and each encountered increased premiums, decreased participation, and general destabilization of the market for individual insurance. Amicus states (Br. 44) that four of the seven States that enacted guaranteed-issue and community-rating requirements without a minimum coverage provision (Maine, New Jersey, New York, and Vermont) did not repeal those requirements or enact a minimum coverage provision. But the experience of these States hardly supports the conclusion that guaranteed issue

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start an adverse selection cycle," and concluded that "the nongroup exchange may not be viable in some states without an individual mandate." *Id.* at 8. The Lewin Group study that amicus cites (Br. 40) acknowledged that its findings differed from those of other analysts and also noted that, if "consumers are about one-third less risk averse than in our analysis, premiums increase by 18 percent and 9.3 million people lose coverage." John F. Sheils & Randall Haught, *Without the Individual Mandate, the Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted*, Health Affairs, Nov. 2011, at 1, 2, 6-7.

and community rating can function effectively, or even avoid making matters worse, in the absence of a minimum coverage provision.

As an initial matter, it is not the case that all the States amicus identifies have adhered to their original guaranteed-issue and community-rating requirements. Most insurers pulled out of Maine after it adopted its insurance reforms, *House Hearing* 117, and that State recently relaxed community-rating requirements, permitting greater variation in premiums by age and geographic location. 2011 Me. Laws 114-116 (amending Me. Rev. Stat. Ann. tit. 24-A, § 2736-C(2) (Supp. 2011)). In 2008, New Jersey likewise relaxed its community-rating rules to allow premium variation by age. 2008 N.J. Laws 561-562 (Ch. 38, § 9 ("Modified community rating")) (amending N.J. Stat. Ann. § 17B:27A-2 (West Supp. 2011)). In 2006, Vermont established a health-care reform commission to provide "needed analysis and criteria for implementing a health insurance requirement by January 1, 2011 if less than 96 percent of Vermonters have health insurance by 2010." 2006 Vt. Acts & Resolves 478 (Vt. Stat. Ann. tit. 2, § 902(a)(3)(D) (2010) (repealed 2011)). That effort by Vermont and other possible market reform efforts in the three other States amicus identifies were overtaken by enactment of the Affordable Care Act. Indeed, in 2011 Vermont enacted a statute providing that the State will seek a waiver of certain provisions of the Affordable Care Act in 2017 in order to implement a single-payer health-insurance system for its residents. 2011 Vt. Acts & Resolves 242 (Pub. Act No. 48, § 2(a)); see Gov't Minimum Coverage Reply Br. 12 (discussing Affordable Care Act's state innovation waiver provision).

Equally to the point, amicus cites no positive discussion of those States' experiences in the record before Congress, and, in fact, what Congress heard about them was uniformly negative. See Gov't Br. 48-50 & n.22; AHIP Amicus Br. 34. Any comprehensive analyses of those States' experiences would hardly have led Congress to view them as models for the Nation. For example, "the prediction" that the individual insurance market in New York after enactment of guaranteed issue and community rating would "become essentially a widely dispersed high-risk pool * * *, in which enrollment [would] continue to shrink and rates [would] continue to rise faster than inflation, *has come to pass.*" Peter Newell & Allen Baumgarten, *The Big Picture: Private and Public Health Insurance Markets in New York* 127 (2009) (emphasis added; internal quotation marks and footnote omitted); see Stephen T. Parente & Tarren Bragdon, *Healthier Choice: An Examination of Market-Based Reforms for New York's Uninsured* i (2009) (Exec. Summary) ("[A]s a result of a significant increase in the cost of private-insurance coverage for individuals, the market for individual health insurance in New York has nearly disappeared, declining by 96 percent since 1994."); see also *id.* at 5. A 2004 study of New Jersey's Individual Health Coverage Program "point[ed] to a market that [was] heading for collapse." Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, Health Affairs, July/Aug. 2004, at 167, 167-168. "Enrollment * * * declined from a peak of 186,130 lives at the end of 1995 to 84,968 at the end of 2001. In addition, premiums * * * increased two- to threefold above their early levels." *Id.* at 168.[13] The fact is that those States that enacted guaranteed issue and community rating experienced harmful effects in the individual insurance market, with the only variable being how quickly and how drastically the market deteriorated. That experience amply supports Congress's judgment that the minimum coverage provision was essential to the Act's guaranteed-issue and community-rating reforms.

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[13] See also Susan Besio, Director, Health Care Reform Implementation, Vermont Agency of Admin., *Vermont Health Care Reform: 2007 Annual Update to 2006 Five-Year Implementation Plan* 10 (Feb. 2008) ("[T]he Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, and limited carrier participation."); Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed*

d. Finally, amicus argues (Br. 45-46) that, if the guaranteed-issue and community-rating provisions were not in place, the state-based health-insurance exchanges would be less effective in achieving the benefits of standardization. It is certainly true that the exchanges would function better with the guaranteed-issue and community-rating provisions that without them. Gov't Minimum Coverage Br. 31. Nonetheless, exchanges would still serve as central and transparent marketplaces that would reduce premium costs through increased competition and economies of scale even without those market reforms. Gov't Br. 37. Indeed, Utah operates an exchange without guaranteed-issue or community-rating rules. *Ibid.* Given Congress's express findings and the ample empirical evidence before it on the importance of a minimum coverage provision, there is little reason to believe that it would have wanted to preserve guaranteed issue and community rating without a minimum coverage provision (and thereby run the risk of creating an adverse selection spiral in the individual insurance market) solely because of their connection to enhanced functioning of the exchanges.

Issue and Community Rating Reforms on Individual Insurance Markets 12 (July 10, 2007) (Maine's insurance reforms "reduced availability of individual coverage * * * by driving almost all carriers out of the market [and] contributed to increases in premiums.").

* * * * *

For the foregoing reasons and those stated in the government's opening brief, in the event the Court invalidates the minimum coverage provision, it should vacate the court of appeals' judgment addressing the severability of provisions of the Act that do not apply to petitioners or are subject to statutory bars to review. To the extent the Court reaches the issue of severability, it should reverse the portion of the judgment of the court of appeals finding the minimum coverage provision severable from the guaranteed-issue and community-rating provisions, but otherwise affirm the judgment of the court of appeals finding the minimum coverage provision severable from the remainder of the Act.

Respectfully submitted.

DONALD B. VERRILLI, JR.
Solicitor General

MARCH 2012

is precisely what those findings embody.[4] *Amicus* mistakenly suggests the States ask the Court to focus on something quite different, namely, whether, "as a practical matter, guaranteed issue and community rating can[] work in an acceptable way without the countervailing effects of" the mandate. *Amicus* Br. 33. But the States fully agree with *Amicus* that "this kind of predictive factfinding about the interplay of complex economic forces falls more naturally within the scope of legislative, rather than judicial, competence." *Amicus* Br. 34. That is why the Court should not second-guess Congress' judgment that the insurance regulations were too costly—both fiscally and politically—to enact without an individual mandate to subsidize them.

Yet despite his professed disagreement with that kind of "empirical" approach to severability, *Amicus* Br. 6, that is precisely what *Amicus* invites the Court to do. According to *Amicus*, the Court may leave the insurance regulations in place because eliminating the mandate would not be "so calamitous that no rational Congress could favor that limited remedy." *Amicus* Br. 35. But that is not the standard. This Court does not review statutes the way it reviews allegedly inconsistent jury verdicts. The standard is not calamity or whether any rational Congress could pass such a statute, but rather "what the Congress that actually passed the Act" would have wanted. Govt.'s Br. 42. As to that question, even *Amicus* is forced to concede that the insurance regulations "were meant to work together with" the mandate and "likely will operate less ideally without" it. *Amicus* Br. 25; *see also Amicus* Br. 9 ("Congress expected those provisions to work in concert").

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[4] The federal government fails to grasp that distinction between severability and constitutional analysis when it erroneously contends that the States' opening brief concedes that the mandate "is necessary to make effective the Act's guaranteed-issue and community-rating insurance market reforms." Govt.'s Br. 26. As the States explained, *see* States' Br. 38 n.16, that Congress' characterization of the relationship between the mandate and those regulations should be accepted for *severability* purposes does not mean it should be accepted for *constitutional* purposes as well. Simply calling the mandate "essential" does not make it a "law[] necessary and proper for carrying into Execution" the commerce power, U.S. Const. art. I, § 8, cl. 18, particularly given that Congress enacted the mandate to *counteract* the effects of those regulations, not to make those regulations effective. *See* States' Minimum Coverage Br. 33–35.

Moreover, *Amicus* simply ignores the States' argument that the political realities were such that Congress could not have enacted the two insurance provisions without the mandate even had it wanted to do so. As the States explained, *see* States' Br. 13, the Act's proponents secured the critical insurance industry support for those regulations only by promising to include an individual mandate to provide the industry with a multi-billion dollar annual subsidy to offset their costs. Thus, "the importance of the [mandate] in the original legislative bargain" cannot be overstated. *Brock*, 480 U.S. at 685. Severability is not a means by which Congress may use the courts to circumvent accountability constraints on its legislative power. *See Pollock v. Farmers' Loan & Trust Co.*, 158 U.S. 601, 636 (1895) (courts may not "substitute for the law intended by the legislature one they may never have been willing, by itself, to enact"). *Amicus* is silent as to why the

Court should leave in place regulations that Congress lacked the support to enact without the promise of the unconstitutional mandate.

Amicus alternatively insists the mandate must be severed "[b]ecause the effects of invalidating the guaranteed issue and community rating provisions could not easily be limited" given their integral relationship to other core provisions. *Amicus* Br. 46. *Amicus*' argument that the *rest* of the Act could not function as Congress intended without those regulations makes a convincing case for *total* invalidation of the ACA. *See supra*, pp. 12–13. But it provides no basis for concluding that Congress believed the insurance regulations could operate in the manner it intended without the mandate. Rather, it underscores that the mandate and the inextricably interrelated guaranteed issue and community rating regulations are at the very heart of the entire Act. Congress' own findings make clear that it did not intend to have one without the other, and without those core provisions "it is evident that the Legislature would not have enacted" the balance of the ACA. *Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932). Accordingly, both those regulations and the rest of the Act must fall with the mandate.

CONCLUSION

The Court should hold the ACA invalid in its entirety.

Respectfully submitted,

PAUL D. CLEMENT
Counsel of Record
ERIN E. MURPHY
BANCROFT PLLC
1919 M Street, N.W.
Suite 470
Washington, DC 20036
pclement@bancroftpllc.com
(202) 234-0090

PAMELA JO BONDI
Attorney General of Florida
SCOTT D. MAKAR
Solicitor General
LOUIS F. HUBENER
TIMOTHY D. OSTERHAUS
Deputy Solicitors General
BLAINE H. WINSHIP
Special Counsel
Office of the Attorney
General of Florida
The Capitol, Suite PL-01
Tallahassee, FL 32399
(850) 414-3300

KATHERINE J. SPOHN
Special Counsel to the
Attorney General
Office of the Attorney
General of Nebraska
2115 State Capitol Building
Lincoln, NE 68508

GREG ABBOTT
Attorney General of Texas
P.O. Box 12548
Capitol Station
Austin, TX 78711

March 13, 2012 *Counsel for State Petitioners*

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

In The
Supreme Court of the United States

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NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, et al.,

Petitioners,

v.

KATHLEEN SEBELIUS, Secretary of
Health and Human Services, et al.,

Respondents.

◆

STATES OF FLORIDA, et al.,

Petitioners,

v.

DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,

Respondents.

◆

On Writs Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

◆

BRIEF OF MEMBERS OF THE UNITED STATES SENATE AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS ON THE ISSUE OF SEVERABILITY

◆

JAMES F. BENNETT
Counsel of Record
ROSEMARIE BLASE
DOWD BENNETT LLP
7733 Forsyth Boulevard
Suite 1410
St. Louis, Missouri 63105
(314) 773-8900
jbennett@dowdbennett.com

CARRIE SEVERINO
Chief Counsel and Policy Director

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae are United States Senate Republican Leader Mitch McConnell, Senator Orrin Hatch, Senator Kelly Ayotte, Senator John Barrasso, Senator Roy Blunt, Senator John Boozman, Senator Richard Burr, Senator Saxby Chambliss, Senator Daniel Coats, Senator Tom Coburn, Senator Thad Cochran, Senator Susan Collins, Senator John Cornyn, Senator Mike Crapo, Senator Michael Enzi, Senator Chuck Grassley, Senator Dean Heller, Senator John Hoeven, Senator Kay Bailey Hutchison, Senator James Inhofe, Senator Johnny Isakson, Senator Mike Johanns, Senator Ron Johnson, Senator Jon Kyl, Senator Mike Lee, Senator Richard Lugar, Senator John McCain, Senator Lisa Murkowski, Senator Rand Paul, Senator James Risch, Senator Pat Roberts, Senator Marco Rubio, Senator Richard Shelby, Senator Olympia Snowe, Senator John Thune, and Senator Patrick Toomey.

As Senators, *amici* are interested in the severability question at stake in this litigation because it lies at the intersection of their own legislative prerogative and the judicial review of the courts. The constitutional authority to draft and enact legislation is held by Congress, and this Court has acknowledged its own need to defer to Congress' will on issues of severability.

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[1] No counsel for any party has authored this brief in whole or in part, and no person other than *amici* or their counsel have made any monetary contribution intended to fund the preparation or submission of this brief. The parties have consented to the filing of this brief.

Amici have strong institutional interests in ensuring that courts respect congressional judgment regarding the importance of laws. This Court has recognized that it should not substitute for that of Congress its own estimation of the importance of provisions to the legislative scheme as a whole. Members of Congress are uniquely situated to balance the many political and policy interests at play in any piece of legislation. In this case the clear intent of Congress – demonstrated through statutory findings, statements by its proponents, and the excision of a severability clause – is that the individual mandate was at the heart of the Patient Protection and Affordable Care Act ("PPACA") and was essential to the passage of the entire law.

Amici also believe that the Eleventh Circuit misconstrued this Court's severability test, overstepping its judicial role in substituting its own view of the centrality of a statutory provision for that of Congress. The facts surrounding the passage of the PPACA demonstrate why the estimation of which statutory provisions are essential to a bill as a whole is decidedly the province of Congress. The strong presumption of severability applied by the Eleventh Circuit not only misstates this Court's precedent, but also disregards Congress' own decision to exclude a severability clause from the statute.

◆

SUMMARY OF THE ARGUMENT

Under the carefully-crafted balance enshrined in the Constitution, the separate branches of government have unique roles. When necessary, each branch must be willing to act to protect that balance of power. Each coequal branch must respect fully the authority of the other branches to act within their constitutionally-mandated spheres. The Constitution delegates to Congress the power to regulate interstate commerce through the enumerated authority of the Commerce Clause. This Court, in turn, may be required to strike down legislation if it exceeds the bounds of that grant of legislative power. When it does so, this Court must craft a remedy, mindful that policy determinations rightfully belong to the legislature, especially when those determinations result in statutes that (a) incorporate conflicting interests, (b) reflect political restraints that prevented passage of a law without certain provisions being included, and (c) make predictive judgments as to the costs and benefits of all provisions included in a legislative solution. These judgments are legislative in nature, and this Court's jurisprudence reflects that they are to be left to Congress.

Congress enacted the PPACA in an attempt to address the societal problems caused by high health care costs. In large part through a fundamental restructuring of the health insurance market, the Act's authors sought to provide for near-universal insurance coverage while trying to minimize any increase in insurance premiums. To achieve these dual goals – significantly increased insurance coverage without significantly increased costs – they included an individual mandate requiring individuals to purchase a minimum level of government-approved insurance even though such a requirement was constitutionally questionable. 26 U.S.C. § 5000A. If this Court holds that the mandate is indeed unconstitutional, as *amici* believe the Court should, the Court must then determine a solution that maintains the proper balance between the legislative and judicial branches.[2] To do so, the Court must follow Congress' intent and evaluate whether Congress would have enacted the statute without the individual mandate. The Court cannot stray from that intent and drastically alter the law through deletion of an essential component, leaving in place a statute which the governing majority would not have chosen.

The authors of the PPACA and its proponents believed the individual mandate was indispensable to their reform scheme. The statutory findings explicitly stated that belief and explained why the mandate was so important to achieve the purposes of the statute. Opponents of the PPACA introduced numerous amendments designed to weaken or outright remove the individual mandate; all were rejected. Several proponents of the law argued in committees and on the floor that the individual mandate was essential to their view of health care reform and that the legislation would not work without the mandate. More than merely a component of the insurance reforms, the majority in Congress believed that the entire health care reform effort of the PPACA was unsustainable without it.

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[2] While *amici* submit that the individual mandate exceeds Congress' power under the Commerce Clause, this brief does not address the arguments in support of that conclusion. Rather, this brief focuses solely on the severability analysis and on the proper remedy if the Court holds the individual mandate unconstitutional.

This Court must defer to this clear expression of Congress' intent regarding the role of the individual mandate. Congress has been given the unique task of determining legislative solutions and assessing what is required to effectuate those solutions. In reaching such policy determinations, Congress must gather evidence, balance competing interests, and work within political constraints. Above all, Congress remains accountable to the people for the ultimate bargain crafted. To maintain the Constitution's balance, this Court cannot ignore Congress' determination as to what is essential to the PPACA's scheme and leave in place a statute Congress would not – and did not – enact.

The Eleventh Circuit erred in applying this Court's severability test to the PPACA. First, the Court of Appeals failed to defer to the congressional understanding of the mandate's centrality and substituted its own predictive judgment as to the requirement's effectiveness. Rather than considering whether the PPACA could function in the *manner Congress intended* without the individual mandate, the Eleventh Circuit looked at the operational independence of some of the other provisions and relied upon its own view of the importance of the mandate. Such determinations should be left to Congress.

Second, the Court of Appeals erred in relying on a strong presumption of severability even though the PPACA does not contain a severability clause. The Eleventh Circuit was able to substitute its own view of the individual mandate's centrality partly because of an erroneous application of a presumption of severability. In particular, the Court of Appeals found that Congress' stated intent as to the indispensable nature of the individual mandate was not enough to defeat the presumption. This conclusion directly contradicts this Court's case law explaining that a strong presumption only applies if the statute contains an express severability clause.

Finally, the Eleventh Circuit erred in dismissing evidence that Congress chose to omit a severability clause from the PPACA. Congress had before it a version of health care reform that contained a severability clause and chose to go in the opposite direction. Congress drafted the PPACA without a severability clause and stressed the essential nature of the individual mandate to the health care reform effort. During the consideration of the PPACA, Congress considered amendments which contained severability clauses applicable to particular topics. At no time during the lengthy debate did anyone suggest that a severability clause should be added that would apply to the individual mandate.

Contrary to the Eleventh Circuit's suggestion, Congress had every reason to include a severability clause in the PPACA. Congress knew the individual mandate was unprecedented and potentially vulnerable to constitutional attack. Congress knew that legal challenges were inevitable and that this Court might be called upon to decide this very issue. If Congress intended for the PPACA to survive without the individual mandate, it could have protected its major legislative reform simply by including a clause which would have guided this Court and resulted in a strong presumption of severability – a clause which was already before it in a prior version of the PPACA. Congress did not do so.

Based on a review of the statutory text and numerous indicia of legislative intent, it is clear that the governing majority believed the individual mandate was essential to its reform effort. The Act's proponents believed the insurance reforms would not work as intended without the mandate and that their design for health care reform in the PPACA would crumble. Under these circumstances, this Court cannot leave a patchwork alternative to the PPACA in place without the heart of the legislation. Rather, such a determination must be left to the elected representatives of the people.

◆

ARGUMENT

> "[The Congressional Budget Office], again, states this requirement is one of the most critical pieces of reform. Without it, we lose coverage for millions of Americans. Without it – without that reform – premiums could spike by up to 15 to 20 percent in the nongroup market. . . . That is the analysis of the nonpartisan Congressional Budget Office. So, clearly, we must resist efforts to weaken the individual responsibility policy in the health care reform bill."

—Senator Baucus, Chairman of the Finance Committee and one of the authors of the PPACA, 156 Cong. Rec. S4729 (daily ed. June 9, 2010).

I. Introduction

The Constitution gives Congress the power to legislate. The President signs legislation into law. If a citizen challenges the legislation, the Courts of the United States review it for conformance to the Constitution. If the citizenry does not approve of the laws that are passed, it votes the Congress and the President out of office. The citizenry does not vote for members of this Court, for this Court does not draft legislation and must remain independent. This is the balance created by the Founders. To maintain this balance, this Court cannot craft legislation itself; only Congress, accountable to the people, can. The people of the United States must be allowed to elect those who create the laws that govern their conduct.

The legislation at issue in this case, the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), was fiercely debated in Congress. Its passage caused fundamental changes in the health insurance market. For the first time, Congress adopted a federal scheme for regulating health insurance in the individual market, a function traditionally left to the States. The PPACA requires a new method of setting insurance premiums (called "community rating") designed to prevent wide disparities in premiums among consumers. It also (in a stricture known as "guaranteed-issue") prohibits an insurer from refusing to issue a policy based on an applicant's preexisting health condition. Its twin goals are to achieve near universal health insurance coverage for American citizens without dramatically increasing their health insurance costs.

In order to accomplish their goals and as the primary means to making the community-rating and guaranteed-issue provisions work as intended, the authors of the PPACA included the so-called "individual mandate" – a requirement that individuals obtain insurance coverage approved by the government or pay a sizeable penalty. 26 U.S.C. § 5000A. The governing majority considered the mandate crucial to ameliorate the impact of other provisions in the PPACA, which would have caused health insurance costs to rise considerably. While essential to the legislative scheme, the individual mandate was an unprecedented exercise of Congress' Commerce Clause power. Relying on the unparalleled nature of the mandate and the lack of any reasoned limiting principle, the Eleventh Circuit held the mandate unconstitutional. U.S. Pet. for Cert., App., 155a-156a (opinion of Eleventh Circuit, summarizing Commerce Clause holding).

If this Court affirms the Eleventh Circuit's constitutional holding, the Court must then decide the fate of the PPACA's remaining provisions. In making this severability determination, the Court will assess whether the law without the unconstitutional provision can operate as Congress intended. *See generally Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987). The individual mandate is at the heart of the PPACA, and the remainder of the statute necessarily depends on its inclusion because without the mandate, the statute's reforms cannot work as intended. Indeed, the proponents of the PPACA knew at the time Congress considered the legislation that without the mandate both the number of uninsured and the price of premiums would skyrocket. In short, without the mandate, Congress' attempted solution to the twin problems of health care coverage and costs disappears. *See* 42 U.S.C. § 18091(a)(2)(I)-(J) (explaining Congress' findings that the individual mandate was essential to broadening the health insurance risk pool and reducing costs).

In addition, the remaining provisions of the PPACA would never have been enacted in their current form without the individual mandate. Deciding to the contrary would upset the constitutional balance of power between the branches. The PPACA is so fundamental a change in the functioning of the health care insurance market, and is so dependent on each of its interlocking provisions, that this Court cannot guess at what provisions Congress would have passed without the individual mandate in the law. What combination of provisions Congress would have been able to enact in the absence of the mandate is something that, if any accountability is to be maintained in the legislative and elective process, must be considered by Congress. Otherwise, voters cannot ever hold their Representatives or Senators accountable for the health care reform legislation as it was passed; their elected representatives did not vote for this law without the mandate and, should this Court uphold the remaining provisions without the mandate, the law, in its final form, will have been approved only by this Court.

II. Courts Must Determine Congress' Intent to Assess Whether an Unconstitutional Provision Is Severable.

When this Court determines that a portion of a law runs afoul of constitutional limits, it must determine the proper remedy. At times, severing the invalid provision may represent appropriate deference to Congress and not inject the Court into the political process. This result is correct when it is clear that the remaining provisions of the law were intended to stand or fall independently of the challenged provision.

At other times, leaving a modified statute in place can change the underlying statutory scheme in a fundamental manner and, if the entire statute is not sent back to Congress, a law that never would have passed would become binding. In such a circumstance the final drafter of the legislation is the Court. To avoid this result, the Court should not rewrite laws by striking essential passages while leaving the remaining portions in place. *Cf. Ayotte v. Planned Parenthood*, 546 U.S. 320, 329-30 (2006); *Randall v. Sorrell*, 548 U.S. 230, 262 (2006) (Breyer, J.). This is especially true where the overall statute is a fully-integrated law that works through multiple, related provisions.

The severability analysis is, at bottom, an inquiry into Congress' intent. *See Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999); *Ayotte*, 546 U.S. at 330. As this Court has explained, an unconstitutional provision cannot be severed from the remainder of the statute if Congress "would not have enacted those provisions which are within its power, independently of that which is not." *Alaska Airlines*, 480 U.S. at 684 (quotations omitted). In other words, the court must determine whether Congress would have preferred no statute at all to what is left after the unconstitutional provision is removed. *Ayotte*, 546 U.S. at 330. This inquiry evaluates the importance of the invalid provision in "the original legislative bargain." *Alaska Airlines*, 480 U.S. at 685. To do so, the court focuses not only on the statute's text and structure but also may consider the legislative history, views of the law's sponsors, statements of other members of Congress, proposed amendments, and votes during the legislative process. *Id.* at 691-96 (discussing these sources in determining Congress' intent for the legislation).

However, the Court is necessarily limited in its ability to interpret the types of legislative history found relevant to this determination and must be careful not to substitute its own analysis of the importance of the provision for that of Congress. With respect, *amici* submit that the legislators themselves are in the best position to determine whether a provision – functionally, structurally, or politically – is essential to a piece of legislation.

A. Congress Considered the Individual Mandate Essential to the PPACA's Reforms.

1. The PPACA's Statutory Findings Highlight the Individual Mandate's Importance to the Entire Legislative Scheme.

The PPACA's text clearly expresses Congress' understanding of the individual mandate's centrality. While the statute does not contain a provision explicitly addressing "severability" by name, the PPACA is far from silent on the issue. Congress included a number of specific findings about the importance of the individual mandate; all of these findings fall into the categories of increasing coverage or reducing costs. In particular, the PPACA explains that its proponents believed the individual mandate will work together with the Act's other provisions to:

- add millions of new consumers to the health insurance market and thereby increase the number of insured Americans;
- achieve near-universal coverage;
- significantly reduce the economic cost caused by the uninsured;
- lower health insurance premiums;
- improve financial security for families;
- minimize adverse selection and broaden the health insurance risk pool; and
- reduce administrative costs.

42 U.S.C. § 18091(a)(2). These are not minor contributions. The PPACA also explains that its proponents believed that the mandate would accomplish these objectives by strengthening the private employer-based health insurance system; significantly reducing the number of uninsured; increasing the economies of scale; and eliminating the incentive to postpone purchasing health insurance. *Id.* Finally, the statute emphasizes that the individual mandate (which it calls "the requirement") is more than a mere component of the legislation; it is *essential* to it:

> The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut

> Federal regulation of the health insurance market. . . . The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold . . . [and] that do not require underwriting and eliminate its associated administrative costs.

Id. at § 18091(a)(2)(H)-(J). In light of these explicit findings, it is clear that the governing majority in Congress believed its goals could not be achieved without the individual mandate.

2. The Legislative History Bolsters the PPACA's Clear Textual Explanation That the Individual Mandate Was Essential to the Health Care Reform Effort.

Legislative history can also serve as evidence of congressional intent regarding the role of an unconstitutional provision. In *Alaska Airlines*, this Court closely examined a statute's legislative history in determining Congress' intent regarding the severability of an invalid legislative-veto provision. 480 U.S. at 691-97. In particular, this Court looked at the statements of members of Congress, reports, and proposed amendments (or lack thereof) to assess the provision's importance. *Id.* The Court found that the legislative veto was mentioned only once during the entire deliberation and clearly was not a congressional priority. Therefore, based on Congress' "scant attention," and the statute's language and structure, this Court held the provision severable. *Id.* at 697; *see also id.* at 694 n.18, 696 (finding the provision "uncontroversial" and of "relative unimportance").

A simple comparison between this case and *Alaska Airlines* speaks volumes. In addition to the explicit statutory findings discussed above, the PPACA's legislative history reveals significant consideration of the role of the mandate. Congress paid a great deal of attention to the individual mandate, and the governing majority believed it was essential to achieving its twin goals. During consideration of the Act, the Senate considered numerous amendments and points of order which would have removed or significantly weakened the mandate's impact. *See, e.g.*, 155 Cong. Rec. S13830 (daily ed. Dec. 23, 2009) (statement of Sen. Ensign raising constitutional point of order); 156 Cong. Rec. S1998-99 (daily ed. Mar. 24, 2010) (consideration of S. Amdt. 3608); 156 Cong. Rec. S2076 (daily ed. Mar. 25, 2010) (consideration of S. Amdt. 3710); *cf. infra* pp. 17-20 (discussion of Sen. Baucus' opposition to other amendments that would have weakened the individual mandate). However, none of these amendments passed.

Congress' understanding of the mandate's indispensable role in the statutory scheme was also manifest in numerous comments by key supporters of the legislation and the expert testimony upon which they relied. One of the Act's chief architects was Senator Baucus, Chairman of the Senate Finance Committee.

Senator Baucus was a passionate defender of the need for an individual mandate in order to achieve the goals of the legislation. To further that end, he made a number of pleas in the Finance Committee and on the Senate floor to protect the mandate from effective elimination or diminution. For example:

September 24, 2009 (before the Finance Committee): In response to a proposed amendment that would allow individuals to opt out of the mandate, Senator Baucus argued,

> I would say it is a mortally wounding amendment because it basically says no more personal requirements, no shared responsibility for individuals. Obviously individuals will just opt themselves out, and that is going to undermine this whole system here. It clearly is going to undermine the system. The system won't work if this amendment passes. Second, as Senator Stabenow is pointing out, it makes the insurance even less affordable in the exchange, and that is not right. If we want this to work, [and] not to make things more difficult. And I just strongly urge everyone not to support the amendment.

Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care

Reform Before the S. Comm. on Finance, 111th Cong. 216 (Sept. 24, 2009).[3]

October 1, 2009 (before the Finance Committee): In response to another proposed amendment granting broad exceptions to the individual mandate, Senator Baucus stated,

> [Y]ou want to gut health reform. If we are serious about having health reform, if we are serious about having the insurance market reformed, if we are serious about making sure that the Americans have health insurance, we have to have shared responsibility. And that shared responsibility is that all Americans are in this, we all have to participate, which means there has to be a shared responsibility for individuals to buy health insurance. Essentially what you are saying, you want to take away the personal responsibility. That is basically what you are saying. And I believe that guts health care reform. This is a killer amendment. This is an amendment which guts and kills health reform. . . . The effect is to say no more coverage, not have universal coverage.

Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care

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[3] Available at http://finance.senate.gov/hearings/hearing/?id=d8083e61-f98b-0204-3389-428e5a1a78e7 (follow Download the Executive Session Transcript hyperlink).

Reform Before the S. Comm. on Finance, 111th Cong. 21-22 (Oct. 1, 2009).[4]

June 9, 2010 (on the Senate floor): During consideration of a post-enactment amendment designed to limit the reach of the mandate, Senator Baucus again defended the provision:

> [The Congressional Budget Office], again, states this requirement is one of the most critical pieces of reform. Without it, we lose coverage for millions of Americans. Without it – without that reform – premiums could spike by up to 15 to 20 percent in the nongroup market. . . . That is the analysis of the nonpartisan Congressional Budget Office. So, clearly, we must resist efforts to weaken the individual responsibility policy in the health care reform bill.

156 Cong. Rec. S4729 (daily ed. June 9, 2010). Indeed, Senator Baucus noted that the "shared responsibility" that resulted from the PPACA requiring all groups to participate in the health care market, including "individuals," was "the basic premise of health care reform." *Id.* "It is," as he put it for those who share his view of health care reform, "about the only way we could make health care reform work in this country." *Id.*

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[4] Available at http://finance.senate.gov/hearings/hearing/?id=d7e5e3c3-eb4e-e366-c063-76040ad6da87 (follow Download the Executive Session Transcript hyperlink).

June 15, 2010 (on the Senate floor): During consideration of another post-enactment amendment that would have expanded exceptions to the individual mandate, Senator Baucus stated, "[The amendment] would eliminate coverage for millions of Americans. It would strike at the heart of health care reform. And the Congressional Budget Office tells us it would also increase premiums for everyone else. The [amendment], just to repeat, would increase premiums for millions of Americans who would have health insurance." 156 Cong. Rec. S4915 (daily ed. June 15, 2010).

Other proponents of the PPACA made similar statements in support of the individual mandate's centrality to the Act's goals of increased coverage and reduced cost. For example during consideration of the PPACA, Senator Jack Reed noted:

> One of the problems we have in the health care system today is healthy, young people – unless they are offered health insurance through their employer – don't typically purchase it. . . . The whole principle of insurance is spreading risk across the largest population to reduce cost. That is precisely what we are doing.

155 Cong. Rec. S13746 (daily ed. Dec. 22, 2009). He described the requirement as "fundamental." *Id.* And then-House Majority Leader Steny Hoyer said it was "a central plank of the Democratic plan." Rep. Steny

Hoyer, Address at the Center for American Progress Action Fund (Dec. 7, 2009).[5]

Senator Bingaman, a senior member of both the Finance Committee and of the Health, Education, Labor & Pensions (HELP) Committee, also stressed the importance of the individual mandate to the twin goals of increasing coverage and reducing costs. For example, during the HELP Committee markup, Senator Bingaman argued, "This requirement, I think, is critical to ensure that everyone, both the sick and the healthy buy coverage, insures appropriate risk sharing, leads to affordable coverage for everybody. I think the CBO indicated that it's a major factor. This requirement is a major factor in expanding coverage." Health Care Reform Legislation Markup Day 9, Part 3 (C-SPAN Video Library July 8, 2009, 4:18 PM EST).[6] Senator Bingaman explained that expanding coverage is "[t]he main thrust of this bill." *Id.* at 4:23 PM EST.

Later, during the Finance Committee's mark-up of the bill, he underscored that making health insurance affordable was also a critical objective for the PPACA's proponents – and that weakening the individual mandate was antithetical to that end:

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[5] Available at http://hoyer.house.gov/index.php?option=com_content&task=view&id=2338&Itemid=57.

[6] Available at http://www.c-spanvideo.org/appearance/557041913.

> [H]ow do we make health care insurance more affordable for folks? . . . And clearly this amendment [which would exempt more people from the mandate] is not one that I see as resulting in making health care coverage more affordable. . . . [T]he effect of this amendment is to reduce the number of people who will have coverage. . . . And that, of course, runs up premiums for everybody else who is insured.

Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform Before the S. Comm. On Finance, 111th Cong. 145-147 (Oct. 1, 2009).[7]

Similarly, two key Chairman in the House of Representatives, Congressman Henry Waxman and Congressman George Miller, noted the centrality of the mandate to the PPACA's objectives. Representative Waxman stated that the individual mandate "may well be the critical component to make insurance work," Rep. Henry Waxman, Chairman, Committee on Energy and Commerce, Remarks at Families USA Health Action 2009 (Jan. 29, 2009),[8] and Representative Miller explained that the mandate was "the only way to make meaningful health insurance reforms and make coverage more affordable," Rep. George Miller, Chairman, Education and Labor Committee, Statement After Bipartisan White House Health Reform Summit (Feb. 25, 2010).[9]

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[7] Available at http://finance.senate.gov/hearings/hearing/?id=d7e5e3c3-eb4e-e366-c063-76040ad6da87 (follow Download the Executive Session Transcript hyperlink).

[8] Available at http://waxman.house.gov/UploadedFiles/speech_familiesusa_1-29-2009.pdf.

Finally, Senator Franken succinctly summarized the PPACA's proponents' view of the individual mandate and its role in the entire legislative scheme:

> So that is our three-legged stool: accessibility, accountability, and affordability. We don't discriminate against people with preexisting conditions, and so we have a mandate so people don't wait until they get sick or hurt to get insurance. Because you are mandated to get health insurance, we make sure everyone can afford it. A three-legged stool. If you take any leg out, the stool collapses.

157 Cong. Rec. S737 (daily ed. Feb. 15, 2011).

This description by Senator Franken illustrates how the individual mandate was critical to the entire PPACA. The Act sought to accomplish increased coverage ("accessibility") through the insurance reforms and managed costs ("affordability") through Medicaid expansion, direct subsidies and the exchanges. However, these twin goals can only be accomplished with the counterbalance of the third "leg" – the accountability provided by the individual mandate.

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[9] Available at http://georgemiller.house.gov/2010/02/statement-after-bipartisan-whi.shtml.

The importance of the individual mandate to the dual goals of the PPACA was confirmed by expert testimony. Significantly, the Director of the Congressional Budget Office, Douglas Elmendorf, testified that the mandate made a major difference in the scope of health insurance coverage under the Act:

> A mandate is – just briefly, to address your question of the role of a mandate – that makes a big difference, in our estimation, on the number of people who end up getting coverage, who would not otherwise have it. And that's partly because the mandate has a financial penalty attached to not following it, and it's partly because people follow the rules. . . .

Health Care Reform Legislation Markup Day 9, Part 1 (C-SPAN Video Library July 8, 2009, 5:49 mark).[10]

The professional staff of the Finance Committee also underscored that it was, in fact, "very difficult, if not impossible, to achieve the same levels of coverage without having a personal responsibility requirement. . . . [T]o achieve the coverage levels that [the drafters of the PPACA attained] would essentially require something like what we've put in the mark." Continuation of the Open Executive Session to Consider an Original Bill Providing for Health Care Reform Before the S. Comm. on Finance, 111th Cong.

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[10] Available at http://www.c-spanvideo.org/program/MarkupDay9.

412-414 (Sept. 29, 2009) (statement of Yvette Fontenot).[11]

Much like the descriptive statutory findings, these comments of the Act's proponents – supported by the testimony of the CBO – and the consistent defeat of weakening amendments reveal that the majority in Congress believed the individual mandate was a critical component of the crafted legislation. They would not have included the insurance reforms without the essential counterbalance of the individual mandate, nor would they have chosen to approach health care reform as accomplished by the PPACA without the heart of the legislation, the insurance reforms. When a court is invalidating a provision that the legislators unambiguously viewed as indispensable to their overarching goal, it should not engage in the essentially legislative task of dissecting the statute rather than letting it fall as a whole.

B. This Court Should Defer to Congress' Understanding of the Centrality of the Individual Mandate Because the PPACA Was an Inherently Political Exercise.

Courts should defer to Congress' stated intent because the determination that a particular provision is essential to accomplish the overall statutory goals is a quintessential policy decision. As with other policy decisions, Congress' assessment of a statute's critical components is informed by consideration of numerous, potentially contradictory, and not-always-quantifiable interests. For this reason, courts should not easily dismiss Congress' expressed intent. As has been aptly described, "Congress' prerogative to balance opposing interests and its institutional competence to do so provide one of the principal reasons for deference to its policy determinations." *Salazar v. Buono*, 130 S. Ct. 1803, 1817 (2010) (Kennedy, J.).[12] As an elected body, Congress' resolution incorporates considerations beyond the courts' province, and Congress' members can be held accountable if the American people disapprove of the balance struck.

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[11] Available at http://finance.senate.gov/hearings/hearing/?id=d7f3a956-9ef2-b6c0-6486-3755d1b722a6 (follow Download the Executive Session Transcript hyperlink).

The legislative process, by design, entails more than a court could possibly review, and only Congress is in a position to evaluate all of the factors and craft a workable solution. These factors include, of course, studies, research, and testimony demonstrating the extent of the problem and the potential impact of proposed solutions. But Congress must also go beyond the studies and testimony and take account of political factors in order to achieve a workable solution that is acceptable to the governing majority. "[L]egislative acts . . . are integrated bundles of compromises, deals, and principles." *Abrams v. Johnson*, 521 U.S. 74, 106-07 (1997) (Breyer, J. dissenting) (quotations omitted).

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[12] The Court should defer to Congress' policy determination regarding the effectiveness of a chosen reform method. However, it is still the Court's role to assess whether that method is within Congress' limited power to impose as dictated by the Constitution. *See, e.g., Citizens United v. Fed. Election Comm'n*, 130 S. Ct. 876, 911 (2010) ("When Congress finds that a problem exists, we must give that finding due deference; but Congress may not choose an unconstitutional remedy.").

The legislative process which resulted in the PPACA only serves to highlight the importance of the Court's deference to Congress' policy determination regarding the centrality of the individual mandate. First, the Act's proponents balanced a myriad of concerns in deciding upon the PPACA's particular approach to health care reform. For example, Congress studied the experience of states that had enacted similar insurance reforms without an individual mandate. That experience showed that similar reform without the mandate actually raised the cost of insurance, increased the number of uninsured, and in at least one case, destabilized the insurance market. Uwe E. Reinhardt, Prepared Statement for Making Health Care Work for American Families; Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce, 111th Cong. 11 (Mar. 17, 2009).[13] Congress also noted the experience of Massachusetts, which included an individual mandate as the keystone of its own reforms. *See* 42 U.S.C. § 18091(a)(2)(D); Learning from the States: Individual State Experiences with the

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[13] Available at http://democrats.energycommerce.house.gov/Press_111/20090317/testimony_reinhardt.pdf.

Healthcare Reform Coverage Initiatives in the Context of National Reform (Roundtable Discussion): Hearing Before the S. Comm. on Health, Education, Labor and Pensions, 111th Cong. 8 (2009) (statement of John Kingsdale, Exec. Dir., Commonwealth Health Insurance Connector).[14]

In addition, Congress considered the views of numerous groups likely to be significantly impacted by the reforms. In 2009 alone, no fewer than five congressional committees held dozens of hearings on issues related to health care reform.[15] One of these hearings before the Senate HELP Committee included a health care reform roundtable with representatives from, *inter alia*, the business community, insurance companies, physicians, states, and labor. *See* Healthcare Reform Roundtable (Part I): Hearing Before the S. Comm. on Health, Education, Labor and Pensions, 111th Cong. 6-8 (2009) (statement of Sen.

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[14] Available at http://www.gpo.gov/fdsys/pkg/CHRG-111shrg49460/pdf/CHRG-111shrg49460.pdf.

[15] *See* Hearings, U.S. Senate Comm. on Finance, http://finance.senate.gov/hearings/index.cfm?PageNum_rs=5; Hearings, U.S. Senate Comm. on Health, Education, Labor & Pensions, http://help.senate.gov/hearings/index.cfm?year=2009; Hearings, U.S. House Comm. on Energy & Commerce (Democrats), http://democrats.energycommerce.house.gov/index.php?q=hearings&page=22; Hearings & Bills, U.S. House Comm. on Education & the Workforce (Democrats), http://democrats.edworkforce.house.gov/legislation/hearing?type=hearing&tid=22&tid_1=All&page=5; Calendar Home, U.S. House Comm. on Ways and Means, http://waysandmeans.house.gov/Calendar/Default.aspx?CatagoryID=&Year=2009&EventTypeID=.

Dodd describing backgrounds of witnesses).[16] A number of these participants commented on the importance of an individual mandate, *id.* at pp. 23 (statement of Ronald A. Williams, CEO, Aetna, Inc.), 37 (statement of Samantha Rosman, M.D., Board of Trustees, American Medical Association), 69 (statement of Janet Stokes Trautwein, CEO, National Association of Health Underwriters), and Senator Bingaman noted the diverse panel's "near uniform" understanding of the need for such a requirement within the proposed reforms, *id.* at pp. 91-92.

In crafting the PPACA's "integrated bundle[] of compromises, deals, and principles," *Abrams*, 521 U.S. at 106-07, Congress also necessarily worked within the political constraints of the time. The statute was hotly debated, and the governing majority had to carefully balance interests to find an approach that would be acceptable to a sufficiently broad support base. Proponents of the bill had to fight for every vote in the Senate to avoid measures which would have defeated the effort.

To that end, the PPACA, as it passed the Senate, included a number of provisions offering highly-specialized and substantial benefits to the states of key, holdout senators. For example, Nebraska received an exemption from the state share of Medicaid expansion worth $100 million, Patient Protection and

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[16] Available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_senate_hearings&docid=f:50510.pdf.

Affordable Care Act, Pub. L. No. 111-148, § 10201(c)(4) (2010), and, along with Michigan, an exemption from a substantial excise tax for non-profit insurers in those states, *id.* § 10905. Similarly, Louisiana received an increase of $100-$300 million in federal aid to Medicaid recipients in the state. *Id.* § 2006. Vermont and Massachusetts were also given additional Medicaid funding, *id.* § 10201(c)(4), and the Act included Medicare Advantage protections that heavily benefited Florida, *id.* § 3201.

Thus, the Act's proponents considered contradictory interests, worked within political constraints which dictated the need for certain provisions, and made predictive judgments as to the impact of the statute's various requirements. All of these considerations resulted in a hard-fought legislative bargain that fundamentally restructures a significant segment of the United States' economy. As with all legislative bargains, the Court defers to the policy determinations inherent in the PPACA's bargain because a reviewing court cannot begin to divine how these varied interests and constraints worked together to form the legislative balance. The Act's proponents clearly believed the individual mandate was critical to their objectives, and they did not want the legislation without that essential piece because of the harm its absence would cause. This policy judgment was traditional legislative work, and the courts must defer to Congress' assessment.

III. The Eleventh Circuit Misconstrued This Court's Severability Test.

A. The Eleventh Circuit Failed to Defer to Congress' Expressed Intent Regarding the Role of the Individual Mandate.

Given the level of deference due and Congress' peculiar institutional competence, courts should be wary of substituting their own view of a statutory provision's centrality for that of Congress. The Eleventh Circuit ignored this important restraint on its remedial power and did just that.

In misapplying this Court's severability test, the Eleventh Circuit erroneously concluded that the individual mandate was severable from all other provisions of the PPACA. U.S. Pet. for Cert., App. 172a-186a. The Eleventh Circuit first concluded that most of the Act's provisions clearly operated independently of the individual mandate and, therefore, were still valid. 174a-176a. The Court of Appeals then assessed whether two of the key insurance reforms, community rating and guaranteed-issue policies, could also survive. 177a-186a. The Court noted Congress' findings as to the essential nature of the mandate but concluded that Congress was wrong. *Id.* According to the Eleventh Circuit's assessment, the PPACA's other provisions accomplish many of the same objectives as the individual mandate, 181a, and the mandate has a "limited field of operation," 182a.

Under the guise of respect for Congress, the Eleventh Circuit left in place a statute that Congress did not want and never would have enacted. 172a. Indeed, the Court of Appeals' severability determination ignores fundamental principles of this Court's test and fails to defer to Congress' intent in two critical respects. First, the Eleventh Circuit erroneously conducted only a superficial analysis as to whether some of the PPACA's provisions were operationally independent. 174a-176a. In *Alaska Airlines*, this Court recognized that even if the remaining provisions can function independently that does not answer the severability question. 480 U.S. at 684-85. Rather, the Court acknowledged that simple operational independence alone may "indicate little about the intent of Congress." *Id.* at 685. Congress may have made different policy choices if it had known the provision was invalid. Therefore, courts have to look beyond whether the remaining provisions can function as a law and determine whether the statute, as modified, would function in the *manner* intended by Congress. *Id.*

The Eleventh Circuit ignored this distinction and only considered the "stand-alone nature . . . of the Act's provisions" and "their manifest lack of connection to the individual mandate." 176a. In so doing, the Court of Appeals ignored clear evidence that Congress would not have enacted health care reform in the vehicle of the PPACA without the mandate. *See* Section II.A, *supra*. The Act's authors chose to restructure the health insurance industry in an attempt to obtain near-universal coverage and lower health care costs. The governing majority understood that reforming the health insurance industry in this manner necessarily entails an individual mandate. The statute does not achieve their intended goals of expanded coverage and reduced costs without the insurance reforms and the accompanying individual mandate. *Id.* Without the "leg" of the individual mandate, the "three-legged stool" that is the PPACA falls. 157 Cong. Rec. S737 (daily ed. Feb. 15, 2011) (statement of Sen. Franken).

The Eleventh Circuit also failed to give appropriate deference to Congress' policy assessment in evaluating the relationship between the individual mandate and the insurance reforms. Instead, the Court of Appeals erroneously substituted its own predictive judgment as to the mandate's effectiveness in preventing such undesirable consequences as an increase in the number of uninsured and higher insurance premiums. 177a-186a. In essence, the Eleventh Circuit held the individual mandate severable from the insurance reforms because the Court decided the mandate was not really all that necessary. *Id.* This conclusion is directly contrary to the language of the PPACA, to the arguments of numerous proponents of the legislation, and to the assessment of the CBO. *See* Section II.A.2, *supra*. The Eleventh Circuit failed to defer to Congress' traditional legislative authority, and its resulting severability holding cannot stand.

B. The Eleventh Circuit Erroneously Applied a Strong Presumption of Severability Even Though Congress Chose to Omit a Severability Clause.

1. Strong Evidence of Non-Severability Is Necessary Only If the Statute Contains an Express Severability Clause.

The Eleventh Circuit also erred in relying heavily on a presumption of severability to reject Congress' assessment that the individual mandate was indispensable to the PPACA's overall reform efforts. The Eleventh Circuit's application of this presumption directly contradicts this Court's severability jurisprudence. While recognizing that a strong presumption for severability may be warranted, this Court has linked the presumption to a statutory severability clause:

> [T]he *inclusion of such a clause* creates a presumption that Congress did not intend the validity of the statute in question to depend on the validity of the constitutionally offensive provision. *In such a case*, unless there is strong evidence that Congress intended otherwise, the objectionable provision can be excised from the remainder of the statute.

Alaska Airlines, 480 U.S. at 686 (citations omitted) (emphasis added). This principle is consistent with the deference due Congress' determinations regarding the role of statutory provisions. If Congress states that a provision can be severed from a statute without injuring the whole, the court should respect that policy decision.

However, when Congress does not express a desire for severability by including a clause in the statute, the Court does not simply assume such an intent, particularly when there is evidence to the contrary. Rather, the Court considers the statute's text and legislative history to *discern* Congress' intent. This Court's *Alaska Airlines* analysis illustrates the point. After explaining the presumption, the Court noted that the parties disputed whether such a clause applied to the statute at issue in the case. 480 U.S. at 686-87. This Court concluded that it did not need to resolve the issue because Congress' intent was clear *without the aid of a presumption*. *Id*. at 687. The Court proceeded to analyze the expressions of Congress' intent in the statute and legislative history without any special weighing in favor of severability. *Id*. at 687-97.

The Eleventh Circuit's analysis below directly conflicts with *Alaska Airlines* by requiring strong evidence of Congress' preference for non-severability even though the PPACA does not contain a severability clause. Under the Court of Appeals' approach, the court's inquiry is the same with or without the statutory clause. That simply is not the law. Indeed, the Eleventh Circuit went a step further and used the "presumption," in the face of clear contrary evidence, to overcome Congress' stated determination that the mandate was essential to its intended regulation of the health insurance market. 184a. Specifically, the Eleventh Circuit found that Congress' express findings "do not tip the scale away from the presumption of severability." *Id.* In so doing, the Eleventh Circuit essentially turned the severability analysis on its head.

2. The Eleventh Circuit Erred In Dismissing the Fact That Congress Chose to Omit a Severability Clause.

The Eleventh Circuit also too readily dismissed the circumstances surrounding the absence of a severability clause in the PPACA. Before the Senate considered the PPACA, Congress had before it a health care reform bill which contained an express severability clause. H.R. 3962, 111th Cong. § 255 (as passed by House, Nov. 7, 2009). However, in drafting the PPACA proposal, Congress moved in the opposite direction. Rather than including a clear indication that individual provisions were dispensable, Congress left out the severability clause and introduced language explaining that the individual mandate was essential to the PPACA's intended reforms. *See* 42 U.S.C. § 18091. This was not mere silence; it was a choice.

The Eleventh Circuit ignored this evidence of congressional intent because it believed a severability clause was superfluous. U.S. Pet. for Cert., App. 175a-176a. On the contrary, the authors of the PPACA had every reason to include a severability clause if that was what they intended. The Act's proponents well-understood that the individual mandate was an unprecedented exercise of the Commerce Clause power; Congress' own lawyers noted that its constitutionality was questionable. U.S. Pet. for Cert., App. 319a, 326a-327a (opinion of Vinson, J. on summary judgment) (citing legal opinion of Congressional Research Service). Moreover, they knew that legal battles challenging the provision were already in the works and that the courts would thus be called upon to determine whether the mandate was valid, and if not, whether the rest of the PPACA should survive. *Id.* at 355a. Far from being unnecessary, a severability clause would have provided clear guidance to the courts as to Congress' intent if the mandate failed and would have created a strong presumption in favor of severability.

Furthermore, Congress considered other specialized amendments containing severability clauses during the long debate of the PPACA but never indicated that such a clause should be applied to the individual mandate. During the Senate's consideration of the initial bill, the Senate voted on 31 amendments, motions, and points of order covering a wide range of subjects, and Senators submitted dozens of additional amendments.[17] Four amendments contained a severability clause related to a particularized topic.

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[17] *See* Amendments for H.R. 3590, http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.3590: (follow "Amendments" hyperlink).

See 155 Cong. Rec. S12073, 12086-87 (daily ed. Dec. 1, 2009) (S. Amdt. 2793); 155 Cong. Rec. S12335-36 (daily ed. Dec. 3, 2009) (S. Amdt. 2862); 155 Cong. Rec. S12924-25 (daily ed. Dec. 10, 2009) (S. Amdt. 3131); 155 Cong. Rec. S12947, 12961 (daily ed. Dec. 10, 2009) (S. Amdt. 3156). The Senate voted on 41 amendments and motions during consideration of the House amendment package;[18] one contained a specialized severability clause. 156 Cong. Rec. S2070-71 (daily ed. Mar. 25, 2010) (S. Amdt. 3700).

Contrary to the Eleventh Circuit's suggestion, U.S. Pet. for Cert., App., 175a-176a, Congress is clearly not averse to severability clauses when that is its intent. However, at no time during the lengthy consideration of the PPACA did a member of Congress suggest that the PPACA should be amended to include a severability clause applicable to the individual mandate.

Quite simply, it is difficult to believe that the Act's proponents intended the individual mandate to be severable but chose to leave the future of their dramatic legislation to the Court's discretion by excluding a severability clause. Such a proposition is all the more untenable given the fact that Congress had severability clauses before it during consideration of the Act and given the statute's description of the individual mandate as "essential" to accomplishing its goals.

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[18] *See* Amendments for H.R. 4872, http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.4872: (follow "Amendments" hyperlink).

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CONCLUSION

This is not a circumstance in which severing a provision respects the power and role of the politically-responsive legislature. Quite the opposite. As a political body, the governing majority in Congress believed the individual mandate was essential to the success of the PPACA. They knew that the individual mandate would not be popular with a great many people, and that the mandate was of questionable constitutionality. However, the Act's proponents also knew that their approach to health care reform simply would not work without it. Their objective through the PPACA was to increase the number of Americans with insurance coverage without considerably increasing costs. Neither objective can be achieved through the PPACA without an individual mandate.

Like the reforms themselves, Congress' assessment of what is necessary to achieve them is a policy decision uniquely within its competence. If Congress exceeds its limited power in crafting the heart of the reforms, this Court cannot create an alternative solution. *Ayotte v. Planned Parenthood*, 546 U.S. 320, 329-30 (2006). Having determined that these reforms will not work without the mandate, Congress must then go back to the drawing board. For, unlike the

Court, Congress must answer to the people for the legislative bargain crafted. "In a democracy, it is the electorate that holds the legislators accountable for the wisdom of their choices." *I.N.S. v. Chadha*, 462 U.S. 919, 997 (1983) (White, J., dissenting). To protect this fundamental check on governmental power, this Court must respect Congress' policy determination regarding the critical role of the individual mandate. The PPACA cannot stand without it.

Respectfully submitted,

JAMES F. BENNETT
Counsel of Record
ROSEMARIE BLASE
DOWD BENNETT LLP
7733 Forsyth Boulevard
Suite 1410
St. Louis, Missouri 63105
(314) 773-8900
jbennett@dowdbennett.com

CARRIE SEVERINO
Chief Counsel and Policy Director
THE JUDICIAL CRISIS NETWORK
113 2nd Street NE
Washington, DC 20002

Counsel for Amici Curiae

January 6, 2012

AMICUS
CURIAE
BRIEF

Nos. 11-393 & 11-400

In The Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS ET AL., *Petitioners*,
v.
KATHLEEN SEBELIUS ET AL., *Respondents*.

STATE OF FLORIDA ET AL., *Petitioners*,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES ET AL., *Respondents*.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* AARP, CENTER FOR MEDICARE ADVOCACY, INC., MEDICARE RIGHTS CENTER, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE, NATIONAL COUNCIL ON AGING, AND NATIONAL SENIOR CITIZENS LAW CENTER IN SUPPORT OF RESPONDENTS ON SEVERABILITY

Stuart R. Cohen
Stacy Canan
Bruce Vignery
AARP Foundation Litigation

Michael Schuster
AARP

601 E Street, NW
Washington, DC 20049

Rochelle Bobroff
Counsel of Record
Federal Rights Project
National Senior Citizens Law Center
1441 I Street, NW
Suite 1100
Washington, DC 20005
(202) 289-6976
rbobroff@nsclc.org

Attorneys for *Amici Curiae*

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STATEMENTS OF INTEREST[1]

AARP is a nonpartisan, nonprofit organization dedicated to addressing the needs and interests of people aged 50 and older. Since its founding in 1958, AARP has advocated for affordable, accessible health care, as well as improved quality of care and controlled health care costs. In response to the growing number of older people forgoing health care services and facing financial ruin because of health care and insurance becoming increasingly unaffordable and unavailable, AARP sought legislative solutions that would protect Medicare benefits; reduce insurance rate disparities based on age or pre-existing conditions; reduce the rate of health care cost increases, including for prescription drugs; and eliminate waste, fraud, and abuse. When Congress was debating health reform legislation, AARP's advocacy focused on six key priorities: (1) Guaranteeing access to affordable coverage in the individual market for Americans ages 50 to 64 with pre-existing and chronic conditions; (2) Closing the Medicare Part D prescription drug coverage gap ("donut hole"); (3) Lowering drug costs by increasing availability of generic biologics; (4) Reducing costly hospital readmissions through a Medicare Transitional Care

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *amici*, their members or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of *amicus* briefs and have filed letters reflecting their blanket consent with the Clerk.

Benefit; (5) Increasing funding and eligibility for home-and community-based services for people with chronic conditions; and (6) Helping low-income Americans afford premiums and out-of-pocket health costs.

The **Center for Medicare Advocacy, Inc.** provides information, education, and representation to older people and people with disabilities regarding fair access to Medicare and health care. The Center's work involves responding to over 7,000 calls and e-mails annually, producing educational materials, pursuing Medicare coverage for beneficiaries, and engaging in litigation of national significance – with a particular emphasis on issues of import to people with low incomes and long-term conditions. The Center has a substantial interest and expertise in ensuring that due process and access to necessary health care are available to people with Medicare, Medicaid, and disabilities.

The **Medicare Rights Center** is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through direct counseling and advocacy, educational programs and public policy initiatives. Since 1989, Medicare Rights has been helping people with Medicare understand their benefits, navigate the health care system and secure the health care to which they are entitled. Medicare Rights connects real beneficiary experiences to education and policy advocacy — making sure that people with Medicare and their families understand coverage rules and policies, all the while pursuing reforms to systemically improve the Medicare program as a whole. The Medicare Rights Center stresses the importance of Medicare reforms included in the Affordable Care Act and the potential implications the Court's decision could have on access to and the affordability of quality health care for this population.

The **National Committee to Preserve Social Security and Medicare** ("NCPSSM") is a nonprofit organization with more than 3 million members and supporters. Our 30 years of legislative advocacy, policy expertise and educational outreach have focused on the preservation, protection, and strengthening of programs and benefits that ensure access to adequate economic and health care security during retirement or disability. These include, but are not limited to, Social Security, Medicare, Medicaid, and the Older Americans Act. Through a national network of grassroots staff and volunteers, NCPSSM has helped millions of older Americans and their families understand their rights as beneficiaries. NCPSSM leverages its diverse resources to mobilize public support for the creation or defense of laws that protect seniors, the disabled, and their families.

The **National Council on Aging** ("NCOA") is a nonprofit service and advocacy organization that seeks to improve the lives of millions of older adults, especially those who are vulnerable and disadvantaged. NCOA coordinates with thousands of nonprofit organizations, businesses, and governments across the country to improve the wellbeing of older individuals. NCOA strives to better the health of older adults by improving their access to government programs such as Medicare and Medicaid. Along with this, NCOA works hard to strengthen and protect these programs, so that more individuals receive the services that enable them to remain healthy and independent in their communities. The Court's holding will have an enormous impact on the quality and accessibility of healthcare services that are available under Medicare and Medicaid, and NCOA is accordingly concerned with the effects the Court's decision will have on the older population.

The **National Senior Citizens Law Center** ("NSCLC") is a non-profit organization that advocates nationwide to promote the independence and well-being of low-income older persons. NSCLC seeks to ensure that low-income older adults have access to high quality, affordable health care benefits from programs such as Medicare and Medicaid. NSCLC works to advance coordination of care and improve consumer protections for the nine million people who have both Medicare and Medicaid, commonly called "dual eligibles." NSCLC also seeks to expand the use of home and community based services as an alternative to nursing homes or other forms of institutionalization for low-income older adults. For 40 years, NSCLC has served low-income older persons through advocacy, litigation, and the education and counseling of local advocates nationwide. NSCLC's *Federal Rights Project* works to ensure that courts uphold rights provided and protected by federal laws. NSCLC is profoundly concerned about the impact that the Court's decision may have on both the availability and the quality of care and services received by its clients under Medicare and Medicaid.

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), is designed to address numerous inadequacies in America's multifaceted health care system, in which individuals secure access to services and medicines primarily through insurance. Prior to the ACA's enactment, insurance was obtained predominantly via employer-sponsored health insurance, direct purchase of health insurance, Medicare, Medicaid, and/or military health benefits. The vast majority of people age 65 and older have Medicare coverage, but tens of millions of people under age 65 do not have any health insurance. Congress enacted the ACA to address this problem by, among other things, expanding access to affordable coverage for all Americans regardless of an individual's health condition, age, or gender.

Access to health insurance for people under age 65 was not the only goal of the ACA. There are extensive provisions in the ACA of vital importance to the health and well-being of people 65 and older. Nothing in the text or history of the ACA suggests that Congress wanted these significant changes to health care for people 65 and older to be contingent on the constitutionality of the minimum coverage provision. To the contrary, these ACA provisions address long-recognized, deep-seated problems plaguing health care for people 65 and over, including cost-sharing that discouraged the use of prescription medications and preventive care, the lack of accountability for low-quality managed care plans, the high-cost of treating individuals with chronic illnesses, the unnecessary institutionalization of individuals needing long-term care services, and abuse and neglect in nursing homes.

There is no reason to believe Congress, in passing the ACA, wanted older people capable of receiving care in the community to languish in institutions or be subject to abuse and neglect if the minimum coverage provision was invalidated. Similarly, it is not credible to suggest Congress wanted the implementation of the ACA's requirement that brand-name drug companies contribute to the lowering of prescription drug costs for Medicare beneficiaries to hinge on the constitutionality of the minimum coverage provision.

This brief highlights parts of the ACA that greatly benefit people 65 and older and are not related to the minimum coverage provision. To begin with, the ACA reduces cost-sharing for Medicare beneficiaries by substantially reducing the coverage gap for prescription medications (commonly known as the "donut hole"), eliminating cost-sharing for preventive services such as an annual wellness visit and numerous screening services, and prohibiting Medicare Advantage plans from charging higher cost-sharing for chemotherapy and dialysis than permitted under traditional Medicare. These reductions in cost-sharing improve access to specific services under Medicare, of tremendous value to beneficiaries, but have no impact on expanding insurance coverage for uninsured individuals. The ACA further improves the quality of care for Medicare beneficiaries by providing higher bonus payments for Medicare Advantage plans that achieve high ratings for quality, requiring Special Needs Plans to meet quality standards, and limiting Medicare Advantage plan spending on administrative expenses. In addition, Medicare beneficiaries with chronic conditions benefit from several ACA initiatives that target improved and affordable care for this high-cost and high need insured population.

Moreover, the ACA decreases the unnecessary institutionalization of Medicaid beneficiaries by providing financial incentives to states to shift their spending away from institutional care, moving beneficiaries out of nursing homes and back into the community. Likewise, the ACA contains provisions designed to prevent individuals who need long-term care from being institutionalized by improving services in the community. The ACA improves the quality of life for individuals already receiving Medicaid coverage in institutions, allowing them to receive appropriate care in a less restrictive environment for a lower cost.

The ACA also improves the coordination of care for people receiving both Medicare and Medicaid, who have not one, but two forms of government-sponsored health insurance.

Finally, the ACA improves quality and safety in nursing facilities and prevents abuse and neglect of elderly and disabled individuals in nursing and other residential care facilities.

ARGUMENT

Petitioners contend that all of the ACA should fall if the minimum coverage provision, 26 U.S.C. § 5000A (Supp. 2010), is invalidated. State Petitioners Br. on Severability, at 51-59. This argument ignores Congress' clear intent to pursue numerous independent objectives through the ACA. If this Court holds that the individual mandate is not constitutional,[2] all unrelated provisions of the ACA should be left "in force." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328-29 (2006). While the Eleventh Circuit's Appendix supplied a cursory list of provisions in the ACA unrelated to the minimum coverage provision, *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1365-71 (11th Cir. 2011), *cert. granted*, 132 S. Ct. 604 (2011), this *amicus* brief provides a detailed explanation of many

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[2] Many of the *amici* joining this brief regarding severability have submitted separate amicus briefs to this Court supporting the constitutionality of the minimum coverage provision. This brief does not address the constitutionality of the minimum coverage provision.

ACA provisions that are of great importance to persons age 65 and over. These include improvements in the quality of coverage provided to people already insured by Medicare and Medicaid, improvements to conditions and safety for older and disabled individuals who reside in nursing homes or receive care at home, and protection of the elderly from abuse and neglect.

A careful review demonstrates that the "policies Congress sought to advance by enacting" these provisions affecting people age 65 and older can be effectuated without any reliance on the minimum coverage provision. *See Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984). These provisions are "fully operative" regardless of the fate of the minimum coverage provision. *See Alaska Airlines Inc. v. Brock*, 480 U.S. 678, 684 (1987) (quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976)) (internal quotation marks omitted).

This *amicus* brief is submitted in support of Respondents' position that only the pre-existing conditions provision, 42 U.S.C. § 300gg-3 (Supp. 2010), the community rating provision, § 300gg, and the guaranteed issue provision, § 300gg-1, are dependent upon the minimum coverage provision. The rest of the ACA, including, but in no way limited to the provisions highlighted in this *amicus* brief, should remain intact. There is no basis in the "statute's text or historical context" for concluding that "Congress, faced with" the invalidation of the minimum coverage provision, "would have preferred" not to improve the quality of Medicare, Medicaid, and nursing homes. *See Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161 (2010) (citing *Alaska Airlines, Inc*, 480 U.S. at 684).

I. Congress' Goal Of Improving The Quality Of Medicare And Medicaid For Already Insured People Aged 65 And Over Is Wholly Unrelated To Efforts To Decrease The Number Of Uninsured Individuals Under Age 65

The vast majority of Americans aged 65 and older received their health insurance coverage through Medicare prior to the passage of the ACA. In 2010, 98% of people 65 and older had health insurance coverage and 95% of those were covered by Medicare. Ke Bin Wu, AARP Pub. Policy Inst., *Income, Poverty, and Health Insurance Coverage of Older Americans, 2010* at 8-9 (2011), *available at* http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2011/fs232v2.pdf. Only 3.6% of insured individuals under age 65 had Medicare. *Id.* at 10 fig.12.

Medicare Part A covers inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care. Medicare Part B covers doctors' care, including preventive health services, as well as outpatient care, durable medical equipment, and home health care. Medicare Part C covers the same services as Parts A and B, but the insurance is provided by private insurance companies, known as Medicare Advantage Plans. Part C covers managed care, such as health maintenance organizations. Medicare Part D covers prescription drugs. *See* Ctrs. for Medicare & Medicaid Servs., *Medicare and You, 2012*, at 14 (2011), *available at* http://www.medicare.gov/publications/pubs/pdf/10050.pdf.

Low-income older persons who need long-term care services, which are often not covered by Medicare, may obtain additional government-sponsored health insurance through Medicaid. Kaiser Comm'n on Medicaid & Uninsured, *Medicaid and Long-Term Care Services and Supports* 1 (2011), *available at* http://www.kff.org/medicaid/upload/2186-08.pdf. Long-term care services are extremely expensive, with an average yearly cost of $72,000 for nursing home care and an average hourly rate of $21 per hour for home health services. *Id.* Medicaid provides a long-term care services safety net, either in nursing homes or in the community, for those who become impoverished by high medical bills. *Id.* at 1-2. For persons with health insurance age 65 and older, 8.8% had Medicaid coverage. Ke Bin Wu, *supra*, at 9.

In 2010, people 65 years of age and older comprised 12.8% of the total population but only 2% of the uninsured.[3] Carmen Denavas-Walt et al., U.S. Census Bureau, *Income, Poverty, and Health*

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[3] Just under half of the elderly individuals without health insurance are not United States citizens, and half of those individuals had not been in the United States for five years. James W. Mold, et al., *Who are the Uninsured Elderly in the United States?*, J. of American Geriatrics Society, Vol. 52, Issue 4, at 603 (2004). Medicare has citizenship and residency requirements. *See Medicare and You, 2012*, at 28.

Insurance Coverage in the United States: 2010, at 27 tbl.8 (2011), *available at* http://www.census.gov/prod/2011pubs/p60-239.pdf; *USA QuickFacts*, U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/00000.html (last updated Dec. 23, 2011). The lack of uninsured individuals over 65 demonstrates that the efforts to decrease the number of uninsured through the minimum coverage provision were not directed at elderly people.

The minimum-coverage provision is an important component of Congress' efforts to reduce the number of uninsured individuals, 42 U.S.C. § 18091(a)(2)(C)-(D) (Supp. 2010), but that goal is inapplicable to older individuals who were already covered under government-sponsored health insurance. The minimum coverage provision does not affect the quality of health insurance offered under Medicare and Medicaid. *See id.* Therefore, Congress did not intend for the ACA's improvements to those programs to be contingent on the validity of the minimum coverage provision.

Similarly, the minimum coverage provision is crucial for preventing the denial of insurance to people with pre-existing conditions, *see* 42 U.S.C. § 18091(a)(2)(I), but Medicare and Medicaid have never denied coverage for pre-existing conditions. Thus, neither the ACA's minimum coverage provision nor the ban on exclusions for pre-existing conditions in private and employer-sponsored health insurance will alter coverage for people age 65 and older under Medicare and Medicaid.

Instead, insurance coverage for persons 65 and over was improved by wholly unrelated provisions in the ACA, which make substantial changes to the quality of Medicare and Medicaid coverage by enhancing access to specific medical services and products and promoting innovation in the development of targeted services. As discussed below, these changes include reducing Medicare beneficiary cost-sharing to improve access to prescription medications and preventive care; rewarding Medicare managed care organizations for providing high-quality care; facilitating the development of model programs to improve the quality of care for Medicare beneficiaries with chronic conditions; encouraging states to provide Medicaid coverage for long-term care services in the community rather than in institutions; and improving coordination of care for individuals who have both Medicare and Medicaid.

The above-described improvements in the quality of care provided under government sponsored health insurance programs are fully functional, with or without the minimum coverage provision, and hence entirely severable from that provision.

II. The ACA's Reductions Of Cost-Sharing For Medicare Beneficiaries Are Fully Operative Regardless Of The Constitutionality Of The Minimum Coverage Provision

The ACA made significant reductions to the amounts Medicare beneficiaries must pay in co-insurance, thus improving access to specific health services and reducing the financial burden on older persons to obtain these services. Research shows that older people and those with chronic illness may experience more negative health outcomes from cost-sharing than younger, healthier individuals. *See* Sarah Goodell & Katherine Swartz, Robert Wood Johnson Found., *Cost Sharing: Effects on Spending and Outcomes* 3 (2010), *available at* http://www.rwjf.org/files/research/121710.policysynthesis.cost sharing.brief.pdf. Congress' reduction of Medicare cost-sharing, targeted to the older population, is not dependent on its efforts to increase health insurance coverage for younger persons. Moreover, because some costs are picked up by drug manufacturers and managed care insurers, these substantive changes in Medicare law cannot be linked to the "delicate fiscal balance" that Petitioners claim was at the "core" of every ACA provision. *See* State Petitioners Br. on Severability, at 53.

A. Access to Prescription Medications is Improved by the ACA's Reduction of the Medicare "Donut Hole"

The Medicare Part D prescription medication benefit contains a coverage gap, commonly known as the Part D "donut hole." Part D covers the cost of medications up to an initial coverage limit, but then leaves the enrollee without coverage until the enrollee has spent enough on drugs to reach the catastrophic coverage threshold. When in the donut hole, the enrollee must pay out-of-pocket for the entire cost of medications. In 2010, a consumer had to pay $3,610 to get out of the donut hole. Leigh Purvis, AARP Pub. Policy Inst., Health Care Reform Legislation Closes the Medicare Part D Coverage Gap 1 (2010), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs182-doughnut-hole-reform.pdf. Approximately one-quarter of Medicare Part D beneficiaries who utilize Medicare to pay for prescription drugs fell into the donut hole, exceeding the initial coverage limit for prescription medications. *See* Jack Hoadley et al., Henry J. Kaiser Family Found., *The Medicare Part D Coverage Gap: Costs and Consequences in 2007*, at ii (2008), *available at* http://www.kff.org/medicare/upload/7811.pdf. Research demonstrates that Medicare beneficiaries reduce their purchases of prescribed medications in anticipation of reaching the donut hole and then cut their purchases of prescription drugs by 14% after they enter the donut hole, raising concerns about an increased risk of more costly hospitalization and physician services.

Yuting Zhang et al., *The Effects of the Coverage Gap on Drug Spending: A Closer Look at Medicare Part D*, 28 Health Affairs w317, w322 (2009), *available at* http://www.pitt.edu/~ytzhang/zhang_healthaffairs2009.pdf.

The ACA substantially reduces the donut hole, thereby improving access to prescription drugs for Medicare enrollees. By 2020, Part D enrollees will be responsible for only 25% of donut hole prescription drug costs. Purvis, *supra*, at 2. Rather than relying entirely on government expenditures, the ACA requires drug manufacturers to reduce prices for Medicare enrollees in the donut hole. Beginning in 2011, brand-name drug manufacturers must provide a 50% discount on brand-name and biologic drugs for Part D enrollees in the donut hole. *Id.* at 2. Starting in 2013, the Medicare program will begin providing an additional discount on brand-name and biologic drugs for enrollees who are in the donut hole, starting at 2.5% and gradually increasing until it reaches 25% in 2020. 42 U.S.C. § 1395w-102(b)(2)(D)(ii) (Supp. 2010); *see also id.* The Medicare program started picking up a greater share of costs for generic drugs in 2011, gradually increasing until in 2020, the beneficiary receives a 75% discount. 42 U.S.C. § 1395w-102(b)(2)(C)(ii). Thus, by 2020, for both brand-name and generic drugs, enrollees will be responsible for only 25% of the costs they previously had to cover in full.

Moreover, the donut hole as originally enacted was slated to increase the out-of-pocket threshold—the point at which enrollees enter catastrophic coverage—over time, but the ACA changes that as well. Between 2014 and 2019, the ACA adjusts the indexing of the out-of-pocket threshold to help slow its growth. 42 U.S.C. § 1395w-102(b)(4)(B)(i).

The ACA's closing of the donut hole was the culmination of extensive efforts by Congress. Several bills had been previously introduced in Congress to remedy this gap in Medicare Part D coverage, demonstrating that Congress was committed to solving the problem of inadequate Medicare prescription drug coverage, regardless of the minimum coverage provision. The Medicare Part D Coverage Gap Elimination Act of 2006, S. 3764, 109th Cong. (2006), had the purpose of completely eliminating the donut hole. Likewise, the Medicare Prescription Drug Improvement Act, H.R. 1626, 109th Cong. (2005), would have eradicated the coverage gap. This important congressional goal is independent of the minimum coverage provision, and Congress sought the fulfillment of this goal, regardless of the constitutionality of the minimum coverage provision.

B. Access to Preventive Health Services is Improved by the ACA's Reduction of Cost-Sharing for Medicare Beneficiaries

Prior to the passage of the ACA, for many preventive health services, Medicare Part B required the beneficiary to pay a deductible and 20% co-insurance. In 2011, the Part B deductible was $162. Ctrs. for Medicare & Medicaid Servs., *Your Guide to*

Medicare's Preventive Services 7 (2011) [hereinafter *Services Guide*], *available at* http://www.medicare.gov/Publications/Pubs/pdf/10110.pdf. The ACA eliminated cost-sharing for many preventive-care services, including an annual wellness visit during which beneficiaries receive a comprehensive health risk assessment and health care providers take vital signs and basic body measurements to inform a plan for preventive and screening services. 42 U.S.C. § 1395x(s)(2)(FF), (hhh) (Supp. 2010); *see also* Lynda Flowers, AARP Pub. Policy Inst., *Improvements to Medicare's Preventive Services Under Health Reform* 1-2 (2010), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs180-preventive.pdf. The ACA also eliminated cost-sharing for numerous screening services, such as mammograms, Pap smears, bone mass measurement for those with osteoporosis, depression screening, diabetes screening, HIV screening, and obesity screening and counseling. § 1395*l*(a)(1)(T); *see Services Guide*, *supra*; *see also* Nat'l Council on Aging, Nat'l Ctr. for Benefits Outreach & Enrollment, *Quick Reference Chart: Medicare's Preventive Benefits* 1-7 (2012), *available at* http://www.ncoa.org/assets/files/pdf/center-for-benefits/medicare-preventive-benefits-chart.pdf. Other preventive health services that no longer require cost-sharing include medical-nutrition therapy for people with diabetes and kidney disease and smoking-cessation counseling. *Id.*

The impact of cost-sharing may differ according to the patient's age and medical needs. A study of people (who are not poor) under age 62 found that some increased cost-sharing may not adversely affect health outcomes; in contrast, studies of the elderly and chronically ill found that higher cost-sharing can lead to increased emergency-department services, hospitalizations, and nursing-home admissions. Katherine Swartz, Robert Wood Johnson Found., *Cost-sharing: Effects on Spending and Outcomes* 11-12 (2010), *available at* http://www.rwjf.org/files/research/121710.policysynthesis.costsharing.rpt.pdf; Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 Am. Econ. Rev. 193, 211 (2010), *available at* http://dspace.mit.edu/openaccess-disseminate/1721.1/61694; *see also* Amanda Cassidy, *Health Policy Brief: Preventive Services Without Cost Sharing*, Health Affairs (Dec. 28, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=37. The reduction of Medicare cost-sharing for preventive services improves the quality of health care obtained by persons over age 65, increasing access to preventive care to minimize more expensive and restrictive services such as hospitalizations and nursing-home admissions. Chandra, *supra*. This worthy goal of increasing the use of preventive care by Medicare beneficiaries is separate from the minimum coverage provision.

C. *Access to Chemotherapy, Dialysis and Other Services is Improved by the Limitation of Cost-Sharing for Medicare Beneficiaries Participating in Medicare Advantage Plans*

In contrast to the fixed deductible and co-payments of Part B, Medicare Part C allows greater flexibility for Medicare Advantage plans to impose cost-sharing. Managed care plans are encouraged to compete with one another for members by offering different cost-sharing options. The Medicare Payment Advisory Commission reported to Congress in December 2004 that for many services, most Medicare Advantage plans do not require higher cost-sharing than Part B's fee-for-service plan. Medicare Payment Advisory Comm'n, *Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans* 1-2 (2004), *available at* http://www.medpac.gov/documents/Dec04_Cost Sharing.pdf. However, in recent years, some Medicare Advantage plans have significantly increased cost-sharing for specific services needed by less-healthy patients, including chemotherapy and renal dialysis. *Id.* at 1. For instance, some plans charge a 20% co-insurance for chemotherapy, which would cost approximately $5,600 for one year of treatment. *Id.* at 12. Plans that did not increase cost-sharing for these services complained that they were disadvantaged when sicker beneficiaries switched their enrollment out of the higher cost-sharing plans to the lower cost-sharing plans. *Id.* at 2. The Commission recommended "limitations on disproportionate cost sharing for services that are less discretionary in nature." *Id.* at 40.

The ACA pursues this worthy goal of limiting exorbitant cost-sharing for specific services needed by less healthy Medicare beneficiaries in Medicare Advantage plans. The ACA prevents Medicare Advantage plans from imposing higher cost-sharing for chemotherapy and dialysis than permitted under Medicare Parts A and B. 42 U.S.C. § 1395w-22(a)(1)(B)(iii)-(iv). The prohibition on disproportionate cost sharing is totally unrelated to the minimum coverage provision. Since this ACA provision addresses competition among managed care plans, it has no overall impact on the costs of the Medicare program.

III. The ACA's Other Provisions Designed To Improve The Quality Of Health Care For Medicare And Medicaid Beneficiaries Do Not Depend Upon The Minimum Coverage Provision

In addition to provisions addressing cost-sharing, the ACA improves the quality of care for Medicare beneficiaries through multiple additional measures. The ACA targets Medicare Part C, rewarding high-quality care provided by Medicare Advantage plans, requiring Medicare Advantage Special Needs Plans to meet quality standards, and limiting spending on administrative expenses. In addition, the ACA establishes several new programs that explore means to best serve Medicare beneficiaries with chronic illnesses. The minimum coverage provision does not impact these Medicare initiatives.

A. *The ACA Contains Incentives and Requirements to Improve the Quality of Care in Medicare Advantage Plans*

In 2010, 11.1 million people, comprising 24% of all Medicare beneficiaries, were enrolled in Medicare Advantage plans. Kaiser Family Found., Explaining Health Reform: Key Changes in the Medicare Advantage Program 1 ex.1 (2010), *available at* http://www.kff.org/healthreform/upload/8071.pdf. A large majority of beneficiaries in Medicare Advantage plans, 65%, were enrolled in a health maintenance organization ("HMO"). *Id.*

The ACA includes both financial rewards for high-quality plans and requirements designed to improve quality of care for all Medicare Advantage plans. Congress' goal of improving the quality of services provided by Medicare managed-care plans is wholly independent from the ACA's efforts to increase the number of uninsured individuals under age 65.

The Centers for Medicare and Medicaid Services ("CMS") created a quality-rating system for Medicare Advantage plans. Gretchen Jacobson, et al., Kaiser Family Found., *Reaching for the Stars: Quality Ratings of Medicare Advantage Plans*, 2011, at 1 (2011) [hereinafter *Reaching for the Stars*], *available at* http://www.kff.org/medicare/upload/

8151.pdf. The ACA establishes that the ratings will be used to award quality-based payments to Medicare Advantage plans starting in 2012. 42 U.S.C § 1395w-23(n)-(o) (Supp. 2010). Plans with the highest quality ratings qualify for bonus payments and in some counties are eligible for double bonuses. *Id.*, § 1395w-23(o). The bonuses must be used either to provide extra benefits or to lower premiums for enrollees. *Reaching for the Stars*, *supra*, at 2.

The ACA also targets improvement in the quality of care provided by Medicare Advantage plans for beneficiaries with special needs. Medicare Advantage Special Needs Plans ("SNPs") serve individuals who have certain serious chronic diseases and conditions; who have specialized needs, such as people dually eligible for Medicare and Medicaid; or who live in nursing facilities and other institutions. *Overview: Special Needs Plans*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/SpecialNeeds Plans (last modified July 5, 2011). While SNPs were created to improve the quality of care for people with complex health needs, the plans have had inadequate standards of care. Cmty. Catalyst, *Medicare Special Needs Plans: A Critical Need for Quality Standards of Care* 1 (2008), *available at* http://www.communitycatalyst.org/doc_store/publications/medicare_special_needs_plans_a_report.pdf ("[w]ithout quality standards tailored to the specific needs of the populations enrolled in SNPs, too many plans fail to offer a model of care that adequately addresses the difficulties beneficiaries encounter in the current fragmented system.").

Starting in 2012, the ACA requires SNPs to be certified by the National Committee for Quality Assurance (NCQA) and meet standards promulgated by the federal government. § 1395w-28(f)(7). SNPs will be evaluated on, among other things, the plan's (1) specific target population; (2) measurable goals; (3) staffing structure and care-management goals; (4) care management for the most vulnerable subpopulations; and (5) performance and health-outcome measurements. *See id.* (5). The ACA's certification requirement will strengthen efforts to improve health outcomes for SNP beneficiaries, who tend to be Medicare's sickest and most vulnerable.

In another effort to improve care, the ACA limits the amount Medicare Advantage plans are allowed to spend on administrative expenses. Starting in 2014, plans must spend at least 85% of revenues from premiums on medical benefits or activities that improve quality. § 1395w-27(e)(4). If a plan fails to meet the required target for medical spending for three consecutive years, HHS will suspend new enrollment in the plan for one year. If a plan fails to meet the lower administrative costs for five years, the plan's Medicare contract will be terminated. Joyce Dubow, AARP Pub. Policy Inst., *How Health Reform Adjusts Medicare Advantage Payments and Rewards Quality of Care* 2 (2010), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs181-ma.pdf.

B. *The ACA Creates Programs to Improve the Quality of Care for People Suffering With Chronic Conditions and Illnesses*

Almost 95% of healthcare expenditure for persons 65 years of age and older is for the treatment of chronic illnesses. Ctrs. for Disease Control, Merck Inst. of Aging & Health, *The State of Aging and Health in America in 2004*, at 2 (2004), *available at* http://www.cdc.gov/aging/pdf/State_of_Aging_and_Health_in_America_2004.pdf. Three chronic diseases, heart disease, cancer, and stroke, accounted for 60% of the deaths of people age 65 and over in 2000. *Id.* at 1. Chronic illnesses are also responsible for years of pain, disability, loss of function, and loss of independence. *Id.* at 2. At least 80% of Americans age 65 and over have one chronic illness, and 50% have at least two chronic illnesses. *Id.*

The ACA has several provisions targeted to improving the quality of care for patients with chronic illness and reducing the costs to Medicare and Medicaid for serving these beneficiaries. These provisions promote innovation and improvement in the delivery of care to already insured individuals with chronic illnesses and are not in any way linked to the minimum coverage provision.

The Medicare Community-Based Care Transitions Program targets beneficiaries in traditional fee-for-service Medicare who are hospitalized and are at high risk for readmission based on risk factors including chronic diseases, depression, and cognitive impairments. 42 U.S.C. § 1395b-1 note (Supp. 2010) (Community-Based Care Transitions Program). The program provides grants to hospitals, who work in collaboration with community-based organizations, to provide transitional care interventions, such as arranging post-discharge services, providing patient self-management support or caregiver support, or conducting medication management review. *Id.*; *see also* Keith D. Lind, AARP Pub. Policy Inst., *Health Reform Initiatives to Improve Care Coordination and Transitional Care for Chronic Conditions*, 1-3 (2011), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs191-health-reform.pdf.

The Independence at Home program, a demonstration project created by the ACA, similarly targets Medicare beneficiaries who have chronic illnesses and have been hospitalized. 42 U.S.C. § 1395cc–5. This program pays physicians and nurse practitioners to provide primary care services in the home for up to 10,000 fee-for-service Medicare beneficiaries. *Id.* The Demonstration's goal is to improve overall quality of care and quality of life for patients served, while lowering health care costs by avoiding the need for care in institutional settings. Dep't of Health & Human Servs., *Fact Sheet, Independence at Home Demonstration* 1 (2011), *available at* https://www.cms.gov/DemoProjects EvalRpts/downloads/IAH_FactSheet.pdf.

In addition, the ACA establishes an Innovation Center within CMS that is tasked with exploring how to improve delivery of health care to Medicare and Medicaid beneficiaries who suffer with chronic and multiple illnesses because they tend to be the sickest and most vulnerable beneficiaries and the most costly to treat. 42 U.S.C. § 1315a. The Innovation Center's goal is to explore new health care delivery and payment methods that will improve the quality of care for patients, the affordability of coverage and reduce costs to Medicare and Medicaid programs. *Center for Medicare and Medicaid Innovation*, Ctrs. for Medicare & Medicaid Servs., http://innovations.cms.gov (last visited Jan. 22, 2012).

IV. The ACA's Shifting Of Medicaid Long-Term Care Expenditures From Institutions To The Community Improves The Quality Of Life For Older Persons, Pursuing A Policy Unrelated To The Minimum Coverage Provision

Medicaid is "a cooperative federal-state program that provides federal funding for state medical services to the poor." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004). The federal government pays between 50% and 83% of the costs of Medicaid, varying across states according to factors such as state unemployment rates. Barbara S. Klees, Office of the Actuary, Ctrs. for Medicare & Medicaid Servs., *Brief Summaries of Medicare & Medicaid as of November 1, 2011*, at 28 (2011), *available at* http://www.cms.gov/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2011.pdf.

Medicaid provides funding for long-term care services both in institutions, such as nursing homes, and in the community. Most people would prefer to receive care in their homes. Enid Kassner et al., AARP Pub. Policy Inst., *A Balancing Act: State Long-Term Care Reform* 1 (2008), *available at* http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf. And the cost to Medicaid of long-term care in the home is far lower than institutions. In 2004, the average Medicaid expenditure on a beneficiary in a nursing home was $24,585 compared with only $8,440 for community based care. *Id.* at 6 fig.3.

Nevertheless, most states spend their Medicaid dollars primarily on institutional care. In 2006, 63% of Medicaid's nationwide long-term care expenditures were utilized to finance care in nursing homes or other institutions. *Id.* at 2. The amount spent on community-based care varies according to state policies. Oregon set the lead in 2006, with 55% of its Medicaid long-term care expenditures going to community care, while Tennessee was at the opposite end of the spectrum, spending 1% of its Medicaid long-term care funds in the community. *Id.* at 7 fig.4.

The ACA contains several provisions designed to encourage states to shift Medicaid long-term care spending from institutions to the community. Many of these provisions target people already receiving Medicaid coverage for long-term care services in institutions. By providing financial incentives to move people out of institutions and into the community, Congress sought to facilitate an improved quality of life for older persons receiving Medicaid-funded long-term care services. This objective is totally distinct from the minimum coverage provision's goal of achieving universal minimum coverage. Rather than focusing on acquisition of a bare minimum of coverage, the ACA provisions promoting long-term care in the community seek to enable people needing long-term care services who already have Medicaid coverage to reside in the least-restrictive environment, wherein they can enjoy life to the fullest.

A. *The ACA Provides Incentives for Shifting Medicaid Long-Term Care Funding from Institutional to Community Based Care*

The Deficit Reduction Act of 2005 ("DRA"), created the Money Follows the Person program, which gave states an enhanced federal match for the first twelve months of care in the community after a person leaves a nursing home. Pub. L. No. 109-171, §6071, 120 Stat. 4, 102-10 (2005). The DRA required that persons be institutionalized for at least six months to participate, and it authorized states to impose a minimum residency requirement up to two years. *Id.* The federal government reports that from 2008 to 2010, 43 states and the District of Columbia chose to participate in the program, transitioning approximately 12,000 people out of institutions, back into the community. *Money Follows the Person*, Ctrs. for Medicare & Medicaid Servs., http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-

Support/Balancing/Money-Follows-the-Person.html (last visited Jan. 22, 2012).

The Money Follows the Person program was set to expire in 2011. Pub. L. No. 109-171, § 6071, 120 Stat. 4, 102-10. The ACA authorized the program to continue through 2016 and made the program more accessible to institutionalized persons. 42 U.S.C. § 1396a(a), (g)(2), note (Money follows the person rebalancing demonstration). The ACA reduces the minimum residency requirement to 90 days and eliminates the states' authority to require a longer minimum residency. *Id.*; *see also* Nat'l Senior Citizens Law Ctr., *The Medicaid Long-Term Services and Supports Provisions in the Health Care Reform Law* 8 (2010) [hereinafter *Long-Term Provisions*], *available at* http://www.nsclc.org/wp-content/uploads/2011/07/Medicaid-LTSS-Provisions-on-Health-Reform-Law.pdf.

In addition, the ACA establishes a new program, the Community First Choice Option program, to assist with the costs of transitioning from an institution to the community. 42 U.S.C. § 1396n(k). It enables states to provide Medicaid coverage for transition costs including rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities to facilitate the individual's transition to the community. *Long-Term Provisions*, *supra*, at 4.

The ACA also created the Balancing Incentive Payment Program, which targets increased federal matching funds to states that spent less than half their Medicaid long-term care expenditures on community-based care, providing a financial incentive for states to shift Medicaid spending away from institutional care. 42 U.S.C. § 1396d note (Incentives for States to offer home and community-based services as long-term care alternative to nursing homes). In return for these increased federal dollars, participating states must commit to increasing their percentage of long-term care expenditures on community-based care by September 30, 2015. *Id.*; *see also Balancing Incentive Program*, Ctrs. for Medicare & Medicaid Servs., http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html (last visited Jan. 22, 2012).

These programs serve the important objective of moving people and federal dollars from institutional care to community-based care. The minimum coverage provision does not affect ACA provisions implementing this significant goal.

B. The ACA Contains Numerous Provisions Designed to Help People Needing Long-Term Care Obtain Services in the Community and Avoid Institutionalization

Not only does the ACA pursue the goal of reducing institutionalization by targeting currently institutionalized individuals, but also the ACA strives to prevent needless institutionalization of people who could be served in the community.

The Community First Choice Option program discussed above allows states to offer individuals needing a nursing-home level of care Medicaid coverage for community-based attendant services at an enhanced federal matching rate. *Long-Term Provisions*, *supra*, at 8. The ACA also has a provision entitled, "Removal of Barriers to Providing Home and Community-Based Services," which gives states additional flexibility in the type, scope, and duration of services they offer under the Medicaid state plan amendment option. 42 U.S.C. § 1396n note (Oversight and assessment of the administration home and community-based services). Subject to federal approval, states may also offer services in addition to those set forth in the Medicaid statute. *Long-Term Provisions*, *supra*, at 6.

Under prior law, the spouse of a person who sought long-term care in an institution was protected against impoverishment, but if the person sought care in the community, the spouse would have no such protection. The ACA extends Medicaid's spousal protection provisions to spouses of individuals who seek long-term care in the community. 42 U.S.C. § 1396r-5(h)(1)-(2); *see also* Kaiser Comm'n on Medicaid & the Uninsured, *The Medicaid Long-Term Services and Supports: Key Changes in Health Reform Law* 3 (2010), *available at* http://www.kff.org/healthreform/upload/8079.pdf; Lina Walker, AARP Pub. Policy Inst., *Health Care Reform Improves Access to Medicaid Home and*

Community-Based Services, at 4 (2010), *available at* http://assets.aarp.org/rgcenter/ppi/ltc/fs192-hcbs.pdf. This will prevent the unnecessary institutionalization of individuals who can be well-served in the community.

V. ACA Provisions Improving The Coordination Of Services For Individuals Already Insured Under Both Medicare And Medicaid Are Independent Of The Minimum Coverage Provision, Which Is Directed At Currently Uninsured Persons

Approximately 9 million individuals, commonly known as "dual eligibles," have both Medicare and Medicaid coverage. Kaiser Comm'n on Medicaid & the Uninsured, *Dual Eligibles: Medicaid's Role for Low Income Medicare Beneficiaries* 1 (May 2011), *available at* http://www.kff.org/medicaid/upload/4091-08.pdf. They tend to be very low income with substantial health needs, including significant limitations in activities of daily living. They are also more likely than other Medicare beneficiaries to have multiple chronic conditions and live in nursing homes. *Id.* As a result, they are a high-cost population. Spending on individuals who are dually eligible averages five times the cost of other Medicare beneficiaries. *Id.* The issues impacting this high-need and high-cost population who have two sources of health insurance are totally distinct from the minimum coverage provision's effort to reduce the number of uninsured individuals.

The ACA created the Federal Coordinated Health Care Office ("Duals Office") to ensure that dual eligibles have high-quality, cost-effective care. 42 U.S.C. § 1315b(a) (Supp. 2010). The goals of the Duals Office include improving the health and long-term-care quality, care continuity, and the integration of Medicare and Medicaid benefits. *Overview: About the Medicaid-Medicare Coordinated Office*, Ctrs. for Medicare & Medicaid Servs., http://www.cms.gov/medicare-medicaid-coordination (last modified January 19, 2012). In addition, several ACA provisions encourage the federal government and states to explore demonstrations, pilots, and waivers to integrate both the care of dual eligibles and the financing of that care. Nat'l Senior Citizens Law Ctr., *Health Care Reform, Dual Eligibles, and Coverage Expansion* 2 (2010) [hereinafter *Dual-Eligible Coverage Expansion*], *available at* http://www.nsclc.org/wp-content/uploads/2011/07/Health-Reform-Duals-and-Coverage-Expansions.pdf.

Dual eligibles have available to them annually a number of Medicare Part D prescription drug plans, identified as "benchmark" plans, that they may join without paying any premiums. *Low-Income Subsidy*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/States/03_lowincome subsidy.asp (last modified August 25, 2009). The ACA changes the formula for determining benchmark plans, which should increase the number of zero-premium plans in which dual eligibles can enroll, 42 U.S.C. § 1395w-114(b)(2)(B)(iii), thereby giving them increased options for obtaining prescription medications. *Dual-Eligible Coverage Expansion*, *supra*, at 3.

VI. The ACA'S Provisions Improving Quality And Safety In Nursing Facilities And Preventing Abuse And Neglect Of Elderly And Disabled People Are Unrelated To The Minimum Coverage Provision

The ACA's Nursing Home Transparency, Elder Justice Act and Patient Safety and Abuse Prevention Act provisions are vitally important to older and disabled people. These provisions will dramatically improve conditions and safety in nursing homes and prevent abuse and neglect of elderly and disabled people residing in nursing homes and other residential care facilities. These critically important provisions are wholly unrelated to the minimum coverage and underwriting reform provisions.

> Each of these sections would have been considered landmark legislation if enacted on its own. The first, the Elder Justice Act, seeks to combat crimes committed against older people, including financial exploitation and physical and mental abuse. Its companion, the Patient Safety and Abuse Prevention Act, goes a long way toward ensuring that the people who provide care to our seniors and people with disabilities provide a safe

> environment and do not abuse or neglect them. And, finally, the Nursing Home Transparency and Improvement Act will increase transparency and accountability in nursing homes so people will have the information they need to evaluate and compare facilities.

Families USA, *In Perspective: A Closer Look at How the Affordable Care Act Helps Everyone, Better Safety and Quality For Seniors and People with Disabilities* 1 (2010), *available at* http://familiesusa2.org/assets/pdfs/health-reform/in-perspective/Seniors-and-People-with-Disabilities.pdf.

The ACA 's "Nursing Home Transparency and Improvement" provisions include provisions from prior bills that Senators Grassley (R-IA) and Kohl (D-WI) had introduced as the Nursing Home Transparency and Improvement Act of 2009. Senator Grassley noted that "[i]mproving nursing home care requires constant vigilance. ... Some problems keep coming up. They need to be fixed so nursing home quality continues to improve and stay improved. More transparency, enforcement, and staff training are all needed. That's what our bill addresses." Press Release, U.S. Sen. Spec. Comm. on Aging, *Grassley, Kohl Work to Improve Care In Nursing Homes, Introduce Nursing Home Transparency and Improvement Act of 2008* (February 14, 2008), *available at* http://aging.senate.gov/record.cfm?id=295572; *See also* Lawrence R. Siegel et al., *Nursing Home Transparency Act, Despite Uncertainty of*

Consequences, Finally Becomes Law 22 (2010), *available at* http://www.williamsmullen.com/files/Publication/6510b2a5-28c9-454c-bc11-5388d820d6f6/Presentation/PublicationAttachment/578d8055-023b-44c0-91f1-551c73e48341/Siegel-Nied_AHLA_07-2010.pdf. These requirements improve transparency of and access to nursing home information with the intention of improving accountability in nursing homes. Among other things, the ACA requires (1) nursing homes to disclose their owners, operators and financers so they are accountable to residents; (2) nursing homes to establish a Quality Assurance and Performance Improvement Program to improve quality standards; and (3) HHS to collect and report nursing home staffing information. 42 U.S.C. § 1320a-7j(c), (g) (Supp. 2010). In addition, the ACA establishes a pilot program to improve oversight of nursing home chains with reported quality-of-care problems and provide training to workers who care for residents with dementia to prevent abuse. 42 U.S.C. § 1396r(f)(2)(A)(i).

The ACA's Elder Justice Act ("EJA"), 42 U.S.C. § 1305 et seq., among other things, coordinates federal, state, local, and private agencies' activities addressing elder abuse, neglect, and exploitation. ACA's EJA adopted many provisions contained in previous proposals of the Elder Justice Act of 2007, S.1070, and H.R. 1783, 110th Cong. (2007). According to Senator Hatch, the Senate sponsor, "[T]housands of cases of elder abuse, neglect and exploitation go unaddressed each day...This bill will give much needed attention and resources to fight these crimes...." The bill had been continuously reintroduced since 2002. The stated purposes were to create a federal funding stream for state Adult Protective Services, assure that HHS identify an office to provide coordination and technical assistance for the APS system, provide demonstration grants, and define and report on guardianship and other fiduciary concerns.

All of those purposes were fulfilled in the ACA. Through the ACA's EJA, dedicated funding for Adult Protective Services (APS) was established, state demonstration grants testing a variety of methods to detect and prevent elder abuse were created, Elder Abuse, Neglect and Exploitation Forensic Centers to develop forensic expertise was established, and grants for Long-Term Care Ombudsman Programs and to enhance long-term-care staffing were created. 42 U.S.C. § 1397l(d)(1).

The ACA also includes provisions from the Patient Safety and Abuse Prevention Act, which were intended to prevent workers with criminal histories from working within long-term-care settings by creating a comprehensive nationwide system of background checks. Senator Kohl introduced these provisions in recent years seeking to "expand a highly successful three-year pilot program, ... authorized under the 2003 Medicare Modernization Act, which prevented more than 7,000 applicants with a history of substantiated abuse or a violent criminal record from working with and preying upon frail elders and individuals with disabilities in long-term care settings." U.S. Sen.

Spec. Comm. on Aging, *Issues, The Patient Safety and Abuse Prevention Act*, *available at* http://aging.senate.gov/issues/elderfraud/patient_abuse_prevention.cfm (last visited January 23, 2012). The Senate first held a hearing on the criminal background check provisions that are now part of the ACA in 1998. In a 2002 hearing investigating the grave problem of nursing home abuse, Senator Kohl's criminal background check bill was again considered. Parts of the bill were included in the June 2003 Medicare Modernization Act as a pilot program in seven states. In July 2008, the Senate Committee on Aging released a report on the overwhelming success of the pilot program. *Id.*

ACA enables states to conduct national criminal background checks, including fingerprint checks, on individuals who apply for direct patient access jobs in long-term care facilities and with home care agencies that receive funding from Medicare or Medicaid, 42 U.S.C. § 1320a-7l(a), thus eliminating the ability of persons with criminal histories to move from state to state to work with vulnerable seniors and persons with disabilities. *See* Nat'l Health Policy Forum, *The Basics, The Elder Justice Act: Addressing Elder Abuse, Neglect, and Exploitation* 1-8 (2010), *available at* http://www.nhpf.org/library/the-basics/Basics_ElderJustice_11-30-10.pdf.

CONCLUSION

Amici respectfully submit that the Court should hold in accordance with the position of Respondents.

Respectfully submitted,

Rochelle Bobroff
Counsel of Record
Federal Rights Project
National Senior Citizens
Law Center
1441 I Street, NW
Suite 1100
Washington, DC 20005
(202) 289-6976
rbobroff@nsclc.org

Stuart R. Cohen
Stacy Canan
Bruce Vignery
AARP Foundation
Litigation

Michael Schuster
AARP

601 E Street, NW
Washington, DC 20049

Attorneys for *Amici Curiae*

AMICUS
CURIAE
BRIEF

AND
BRIEFS

Nos. 11-393 & 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
ET AL., PETITIONERS

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND
HUMAN SERVICES, ET AL.

STATE OF FLORIDA, ET AL., PETITIONERS

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE AMERICAN ACADEMY OF ACTUARIES AS AMICUS CURIAE SUPPORTING RESPONDENTS ON THE SEVERABILITY ISSUE

MARY E. DOWNS
AMERICAN ACADEMY OF
ACTUARIES
1850 M Street, N.W.,
Suite 300
Washington, DC 20036
(202) 223-8196

KANNON K. SHANMUGAM
Counsel of Record
C.J. MAHONEY
KRISTIN A. FEELEY*
WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
Washington, DC 20005
(202) 434-5000
kshanmugam@wc.com

* Admitted in Illinois and practicing law in the District of Columbia under the supervision of the listed attorneys pursuant to D.C. Bar Rule 49(c)(8).

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BRIEF FOR THE AMERICAN ACADEMY OF ACTUARIES AS AMICUS CURIAE SUPPORTING RESPONDENTS ON THE SEVERABILITY ISSUE

INTEREST OF AMICUS CURIAE

The American Academy of Actuaries (Academy) is a nonprofit professional association for actuaries of all specialties (including health care) practicing in the United States. Founded in 1965, the Academy now has more than 17,000 members nationwide. Before obtaining admission to the Academy, actuaries must satisfy rigorous educational and experiential requirements, and many

States require membership in the Academy before an actuary can perform certain professional services.

As the public voice for the actuarial profession in the United States, the Academy provides independent and objective actuarial information, analysis, and education for the formulation of sound public policy. In particular, the Academy identifies and addresses issues of public interest as to which actuarial science provides a unique understanding. To that end, the Academy files briefs as amicus curiae in cases of interest to the actuarial community in which its expertise may be of assistance.[1]

Critically for purposes of these cases, the Academy played an important role in the congressional debate leading to the enactment of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (Act). The Academy submitted testimony at key hearings and issued public statements commenting on the legislation. See, *e.g.*, *Health Reform In The 21st Century: Proposals To Reform The Health System: Hearing Before The H. Comm. On Ways And Means*, 111th Cong., 1st Sess. 379-384 (2009) (statement of Cori E. Uccello, Senior Health Fellow, American Academy of Actuaries); American Academy of Actuaries, *Critical Issues In Health Reform: Market Reform Principles* (May 2009) <tinyurl.com/aaamay09>.

Throughout the debate, the Academy took the position that the insurance-market reforms being contemplated by Congress—in particular, the prohibitions on denying coverage or charging higher premiums because of a person's medical condition or history—would be workable only to the extent that "a broad cross section" of Americans participate in the reformed health-insurance market. Letter from Cori E. Uccello, Senior Health Fellow, American Academy of Actuaries, to Sens. Reid and McConnell, at 1, reprinted at 156 Cong. Rec. S833 (daily ed. Mar. 1, 2010). The Academy specifically expressed concern that "[i]mplementing market reforms to prohibit insurers from denying coverage and to restrict how much premiums can vary will result in adverse selection and upward pressure on premiums unless lower-risk individuals have incentives to purchase coverage." *Ibid.*

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[1] Pursuant to Rule 37.6, the Academy affirms that no counsel for a party authored this brief in whole or in part and that no person other than the Academy, its members, or its counsel have made a monetary contribution intended to fund the preparation or submission of the brief. The parties have entered blanket consents to the filing of amicus briefs, and copies of their letters of consent are on file with the Clerk's Office.

During the debate, Congress took note of the Academy's expertise on the actuarial aspects of health-care reform. See, *e.g.*, 156 Cong. Rec. S760 (daily ed. Feb. 25, 2010) (statement of Sen. Cornyn); 156 Cong. Rec. S833 (daily ed. Mar. 1, 2010) (statement of Sen. Alexander). And when Congress passed the Act, it recognized the Academy's expertise, specifically directing the Secretary of Health and Human Services to consider the Academy's standards and recommendations in implementing the Act. See, *e.g.*, 42 U.S.C.A. 18061(b)(2)(A)(ii) (ordering the Secretary to use a methodology approved by the Academy to identify high-risk individuals).

The Academy is filing this brief in an effort to assist the Court in understanding the actuarial consequences of a decision to invalidate 26 U.S.C.A. 5000A, the Act's "individual-mandate" or "minimum-coverage" provision. That provision was an integral part of the reforms to the health-insurance market mandated by the Act. In the Academy's view, a decision invalidating the individual-mandate provision, while leaving in place the "guaranteed-issue" and "community-rating" provisions,[2] would have adverse effects on the affordability and accessibility of health insurance in the United States.

SUMMARY OF ARGUMENT

The Academy takes no position on the constitutionality of the individual-mandate provision, or on any of the other issues besides severability that are before the Court in the litigation concerning the Act. The Academy files this brief for the sole purpose of informing the Court of its judgment that, from an actuarial perspective, a decision invalidating only the individual-mandate provision would impose an unsound regulatory regime on the American health-insurance market—a regime that Congress would not have intended.

As a matter both of actuarial science and of basic economics, health-insurance premiums reflect the health-care costs of a plan's enrollees. Rules that allow greater numbers of individuals with high health-care costs to join health-insurance pools necessarily put upward pressure on premiums. Increased premiums, in turn, encourage individuals with lower health-care costs (such as healthier and/or younger individuals) to exit the health-insurance market, driving up premiums even further. If the individual-mandate provision were struck down but the guaranteed-issue and community-rating provisions were left intact, the ultimate result would be less stable health-insurance pools, higher premiums, and a greater-than-projected number of uninsured Americans than if the individual mandate were retained—thus undermining the basic purposes of the Act.

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[2] As discussed below, the "community-rating" provisions actually require only *modified* community rating. See p. 7. In referring to the provisions simply as the community-rating provisions, the Academy follows the practice of the parties.

Recent studies lend support to the Academy's judgment. The Congressional Budget Office and several independent researchers have simulated the effects of implementing the Act with and without the individual mandate. The consistency of their conclusions is striking: eliminating the individual-mandate provision, while retaining the guaranteed-issue and community-rating provisions, would result in higher premiums and less insurance coverage.

ARGUMENT

SHOULD THE COURT INVALIDATE THE INDIVIDUAL-MANDATE PROVISION OF THE ACT, IT SHOULD ALSO INVALIDATE THE GUARANTEED-ISSUE AND COMMUNITY-RATING PROVISIONS

A. Invalidating Only The Individual-Mandate Provision Would Be Inconsistent With Fundamental Actuarial Principles

1. Health care is a subject of boundless complexity. But the basic economic principles behind health insurance are relatively straightforward. Individuals pay premiums to an insurer that guarantees them coverage for medical expenses in the event they become sick or injured. Every individual who holds a similar policy from the same insurer is a member of an insurance pool. In order for an insurer to remain economically viable, total premiums must be sufficient to cover claims and administrative costs. Health-care costs, however, vary widely from person to person: costs for individuals in poor health can greatly exceed those for individuals in good health, and costs for older individuals are typically higher than those for younger individuals. An insurance pool therefore must contain a broad cross-section of risk:

that is, the pool must contain enough lower-risk individuals (whose premiums exceed their claims) to offset higher-risk individuals (whose claims exceed their premiums). Consequently, the key to the survival of any health-insurance pool—and potentially to the survival of the insurer—is to attract lower-risk individuals.

Historically, health insurers have had two primary mechanisms for encouraging lower-risk individuals to buy insurance. The first is the ability to charge lower premiums to those individuals; the second is the ability to refuse coverage for individuals with preexisting conditions. Under the current regime, a lower-risk individual has an incentive to obtain health insurance even if he does not expect to get sick in the near future, because he merely has to pay a relatively modest premium in order to obtain the security of knowing that his medical expenses would be covered if the unforeseen occurs.

Even with those incentives in place, however, health insurers have struggled for decades to bring sufficient numbers of lower-risk individuals into the health-insurance market. Young adults between the ages of 19 and 29 represent the largest and fastest-growing segment of the population without health insurance, and they are uninsured at almost twice the rate of adults between the ages of 30 and 64. See Namrata Kotwani & Marion Danis, *Expanding The Current Health Care Reform Debate: Making The Case For Socio-Economic Interventions For Low Income Young Adults*, 12 J. Health Care L. & Pol'y 17, 27-28 (2009). As a result, there has been a lower than optimal diversity of risk in health-insurance pools, resulting in higher premiums. And when individuals who have voluntarily forgone insurance develop medical conditions that require treatment, many seek emergency-room care that they cannot pay for. Those costs are then passed on to individuals with insurance: studies have suggested that "free riders" impose a "hidden tax" on premiums of between 2% and 10%. See Lucien Wulsin, Jr. & Adam Dougherty, California Research Bureau, *Individual Mandate: A Background Report* 4 (Apr. 2009) <tinyurl.com/crbreport>.

Through the guaranteed-issue and community-rating provisions, the Act eliminates the ability of insurers to deny coverage based on preexisting conditions, eliminates the ability of insurers to base premiums on health status, and substantially limits the ability of insurers to vary premiums based on other characteristics associated with health-care costs. The guaranteed-issue provisions require insurers to provide coverage to all comers and prohibits policy exclusions for preexisting conditions. See 42 U.S.C.A. 300gg-1, 300gg-3, 300gg-4(a). The community-rating provisions prohibit insurers from charging higher premiums except on the basis of how old the applicant is, where the applicant resides, whether the applicant uses tobacco, and whether the policy covers individuals or families. See 42 U.S.C.A. 300gg(a)(1), 300gg-4(b). Insurers are therefore forbidden from charging higher premiums on the basis of health status, claims experience, or recent medical care, see *ibid.*—factors that, as an actuarial matter, greatly increase the likelihood that an individual will make substantial claims on his policy.

In light of the guaranteed-issue and community-rating provisions, the individual-mandate provision of the Act is a vital mechanism for keeping insurance pools fully stocked with lower-risk individuals (and thereby ensuring broad participation in the health-insurance market). As the Court will be aware, that provision penalizes individuals who do not buy health insurance. See 26 U.S.C.A. 5000A. If the individual-mandate provision were struck down but the guaranteed-issue and community-rating provisions were left intact, insurers would be powerless to prevent lower-risk individuals from exiting the system, but would still be required to provide coverage for any higher-risk individual who seeks it—and to do so without the ability to charge higher premiums to account for the likelihood that such an individual will make larger claims. Based on actuarial principles, it is the Academy's conclusion that such a regime would lead to lower diversity in health-insurance pools, higher premiums, and lower coverage rates.

2. The actuarial impact of a decision invalidating only the individual-mandate provision is perhaps best understood through a simplified hypothetical scenario.

Assume that a health insurer operating under the preexisting regime could break even as long as 80% of its pool consists of lower-risk individuals paying premiums of $100 each, and 20% consists of higher-risk individuals paying premiums of $400 each. Implementation of the community-rating and guaranteed-issue provisions, without the individual-mandate provision, will have three primary effects:

First, premiums for higher-risk individuals will go down and premiums for lower-risk individuals will go up. Once the community-rating provisions go into effect, the insurer will no longer be able to charge different premiums by health status and will need to charge each individual $160—the weighted-average premium—in order to break even.

Second, some number of higher-risk individuals, who had been either ineligible for coverage or priced out of the market under the preexisting regime, will now obtain coverage.

Third, some number of lower-risk individuals will either decide not to obtain coverage or choose to opt out of it, as they now will have to pay a higher premium than they would have paid if health status could be used as a rating factor. With the guaranteed-issue provisions in place but without the individual-mandate provision, lower-risk individuals will be able to leave the pool without triggering a penalty, secure in the knowledge that they will be able to reenter the pool should they later develop a condition that requires costly medical treatment.

As a result of those three effects, the ratio of higher-risk individuals to lower-risk individuals in the pool will increase, causing a corresponding increase in the break-even premium. If the resulting pool consists of 70% lower-risk individuals and 30% higher-risk individuals, the average premium would need to increase to $190 (a 19% increase over the weighted-average premium) in order for the insurer to break even. Such an increase could cause even more lower-risk individuals to opt out of coverage, resulting in another increase in the ratio and further upward pressure on premiums. If the resulting pool consists of 60% lower-risk individuals and 40% higher-risk individuals, premiums would need to increase to $220 (a 38% increase over the weighted-average premium in the original pool).

As a conceptual matter, therefore, it is clear that invalidating the individual-mandate provision, while leaving in place the guaranteed-issue and community-rating provisions, would increase premiums and swell the ranks of the uninsured.

B. Recent Studies Support The Conclusion That Invalidating Only The Individual-Mandate Provision Would Undermine The Effectiveness Of Health-Insurance Reform

The problems with invalidating only the individual-mandate provision are more than merely theoretical. A number of studies have attempted to quantify the effects of such a regime. In particular, the Congressional Budget Office (CBO) and several independent researchers have conducted microsimulations comparing the potential effects of implementing the Act with and without the individual-mandate provision.[3] The Academy believes that the studies amply confirm the conceptual proposition set out above: *viz.*, that invalidating only the individual-mandate provision would result in higher premiums and lower coverage rates. Although the studies differ to some extent in their estimates of the magnitude of the effects of implementing the Act with and without the individual mandate, they broadly agree on the nature and direction of those effects. The studies therefore illustrate the need for effective policy mechanisms, such as an individual mandate, to stabilize the market when implementing supply-side mechanisms such as the Act's guaranteed-issue and community-rating requirements.

1. A recent study, conducted by Matthew Buettgens and Caitlin Carroll of the Urban Institute, simulates the Act as if it were fully implemented in 2011. See Matthew Buettgens & Caitlin Carroll, Robert Wood Johnson Foundation & Urban Institute, *Eliminating The Individual Mandate: Effects On Premiums, Coverage, And Uncompensated Care* (Jan. 2012) <tinyurl.com/buettgens> (Buettgens & Carroll). A predecessor to Buettgens and Carroll's model was used in the development of

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[3] Microsimulation is an economic modeling technique that predicts individual reactions to a set of rules, allowing researchers to aggregate the predicted reactions and draw conclusions about the overall effects of a change in the rules. See International Microsimulation Association, *What Is Microsimulation?* <tinyurl.com/microsimulation>.

health-care reform in Massachusetts, and its estimates proved to be accurate. *Id.* at 2 n.9.

Buettgens and Carroll project that, with the individual mandate in place, the Act would "decrease the nonelderly uninsured population by 23.9 million, from 50.3 million to 26.4 million." Buettgens & Carroll 3. "[A]verage premiums in the total nongroup market would be $5,100." *Id.* at 6.[4] The average government subsidy for premiums in that market would be $4,426, resulting in approximately $340 billion in net government spending. *Id.* at 5.

Without the individual mandate, however, Buettgens and Carroll estimate that the Act would decrease the non-elderly uninsured population only by between 8.1 million and 10.5 million, depending on the strength of participation in subsidies and exchange coverage. See Buettgens & Carroll 3. And because of the phenomenon of "adverse selection" described above, average premiums in the total non-group market would rise by some 10% to 20%, to between $5,600 and $6,100. *Id.* at 6. Although net government spending would decline, it would do so only slightly (to between $315 billion and $330 billion), because the lower participation rate would largely be offset by more expensive subsidies. *Id.* at 5. In short, the expected decline in coverage would more than outweigh the modestly positive effect on the public fisc: "[e]ven though the gain in coverage under reform is cut by more than half, the government would only spend 3 to 8 percent less on acute care for the nonelderly." *Id.* at 7.

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[4] Buettgens and Carroll focused on the non-group market because "[t]he effects of not having an individual mandate or an effective equivalent will be most pronounced" in that market. Buettgens & Carroll 7.

2. Microsimulations conducted by the Congressional Budget Office and Jonathan Gruber, an economics professor at the Massachusetts Institute of Technology, model the impact of the Act on employer and individual behavior with and without the individual-mandate provision. CBO estimates that, with the mandate, 23 million non-elderly individuals will be uninsured in 2019; without the mandate, however, approximately 39 million individuals would be uninsured as of that date. See CBO, *Effects Of Eliminating The Individual Mandate To Obtain Health Insurance* 2 (June 16, 2010) <tinyurl.com/cbostudy> (CBO). Similarly, Professor Gruber estimates that eliminating the mandate would "cut the number of newly insured individuals by three quarters"—from 32 million with the mandate to 8 million without it. Jonathan Gruber, Center for American Progress, *Health Care Reform Without The Individual Mandate: Replacing The Individual Mandate Would Significantly Erode Coverage Gains And Raise Premiums For Health Care Consumers* 2 (Feb. 2011) <tinyurl.com/gruberstudy> (Gruber).

Both studies also project higher premiums absent the mandate. CBO estimates an increase of 15% to 20%; Professor Gruber, 27%. CBO 2; Gruber 2. And like Buettgens and Carroll, CBO projects that "the budgetary savings from removing the mandate would be less than proportional to the reduction in insurance coverage." CBO 2. Professor Gruber similarly concludes that "removing the mandate would significantly lower the 'bang for the buck' of health policy, reducing coverage by 50 percent to 75 percent while only lowering costs by 25 percent to 30 percent." Gruber 2. Whatever the exact figures, those studies confirm that invalidating only the individual-mandate provision would have substantial and deleterious effects on the market for health insurance in the United States.

* * * * *

From an actuarial standpoint, it is clear that, in order for the community-rating and guaranteed-issue provisions in the Act to operate as intended, they must be paired with an effective mechanism to ensure broad participation in the health-insurance market, such as an individual mandate. Should this Court follow the lead of the Eleventh Circuit and invalidate only the individual-mandate provision, the Nation will be left with an incomplete and unbalanced package of market reforms, resulting in a system in which "those who enroll [in insurance coverage] would be less healthy, on average, than those enrolled with a mandate" and "adverse selection would increase premiums." CBO 2. That is not an outcome that the Congress that passed the Act would have wanted. However the Court rules on the constitutionality of the individual-mandate provision, therefore, the guaranteed-issue and community-rating provisions should stand or fall together with it.

CONCLUSION

In the event the Court concludes that the individual-mandate provision is unconstitutional, it should reverse the judgment of the Eleventh Circuit to the extent it upheld the guaranteed-issue and community-rating provisions as severable.

Respectfully submitted.

MARY E. DOWNS
AMERICAN ACADEMY OF ACTUARIES
1850 M Street, N.W.,
Suite 300
Washington, DC 20036
(202) 223-8196

KANNON K. SHANMUGAM
C.J. MAHONEY
KRISTIN A. FEELEY*
WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
Washington, DC 20005
(202) 434-5000
kshanmugam@wc.com

JANUARY 2012

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* Admitted in Illinois and practicing law in the District of Columbia under the supervision of the listed attorneys pursuant to D.C. Bar Rule 49(c)(8).

AMICUS CURIAE BRIEF

Nos. 11-393 and 11-400

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STATE OF FLORIDA, ET AL.,
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UNITED STATES DEPARTMENT OF HEALTH
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ON WRITS OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE AMERICAN BENEFITS COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF PARTIAL REVERSAL ON SEVERABILITY

JAMES A. KLEIN
President
KATHRYN M. WILBER
Senior Counsel, Health Policy
AMERICAN BENEFITS COUNCIL
1501 M Street, N.W.
Suite 600
Washington, DC 20005

JAMES R. NAPOLI
Counsel of Record
PROSKAUER ROSE LLP
1001 Pennsylvania Ave., NW
Suite 400, South
Washington, DC 20004
(202) 416-5862
jnapoli@proskauer.com

MARK D. HARRIS
CHARLES S. SIMS
PROSKAUER ROSE LLP
11 Times Square
New York, NY 10036

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INTEREST OF THE *AMICUS CURIAE*

The American Benefits Council (the "Council") is a broad-based nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans.[1] The Council's approximately 350 members are primarily large U.S. employers that provide employee benefits to active and retired workers. The Council's membership also includes organizations that provide services to employers of all sizes regarding their employee benefit programs. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering more than 100 million Americans. The Council frequently participates as *amicus curiae* in cases that have the potential for far-reaching effects on employee benefit plan design or administration.[2]

The Council was involved in extensive discussions with the Congressional leadership and the Administration during the legislative process leading to the enactment of the Patient Protection and Affordable Care Act of 2010,

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[1] All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk. No counsel for a party authored this brief in whole or in part, and no person other than *amicus* made a monetary contribution intended to fund the preparation and submission of this brief.

[2] *See, e.g., Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285 (2009); *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006); *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004); *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581 (2004); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

Pub. L. No. 111-148, 124 Stat. 119, amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (the "ACA" or the "Act"). The Council submits this brief because that background and its general experience with the design and administration of health benefits give it a perspective that may be helpful to the Court in addressing the severability issues posed by the Eleventh Circuit's decision below.

SUMMARY OF ARGUMENT

Although the Council supported the need for reform of the health care system in Congress, this brief does not address any of the questions presented in the companion cases before this Court regarding the constitutionality of the ACA's individual mandate, ACA § 1501, the Anti-Injunction Act, 28 U.S.C. § 2283, or the Medicaid coercion issue based on *South Dakota v. Dole*, 483 U.S. 203 (1987). Rather, the sole question this brief addresses is what remedy should follow in the event that the individual mandate is held unconstitutional.

The Council disagrees with the Eleventh Circuit's holding that the individual mandate is completely severable from the rest of the ACA, because that court's ruling does not take adequate account of the overarching aims of the ACA or the mechanics of the law meant to meet those aims. The Council also disagrees with those parties and amici who argue that, if the individual mandate is invalidated, the Court should discard the balance of the ACA as well. Rather, a holding that a few discrete portions of the ACA are inseverable is required under the cautious severability standards of this Court's cases. The teachings and principles of such cases as *Ayotte v.*

Planned Parenthood of N. New England, 546 U.S. 320 (2006), and *United States v. Salerno*, 481 U.S. 739, 745 (1987) define a vital but necessarily restrained role for judicial invalidation of duly enacted legislation.

Under the test this Court has articulated for determining severability, *see, e.g.*, *Alaska Airlines v. Brock*, 480 U.S. 678, 685 (1987); *Carter v. Carter Coal Co.*, 298 U.S. 238, 312-5 (1936), the Council believes that most of the ACA is severable from the individual mandate. Nevertheless, the Council believes that two sets of provisions are so intimately connected with the individual mandate, and so dependent upon it to function in the manner Congress intended, that they must be held inseverable and, therefore, invalidated if the individual mandate is struck down.

First, the Council agrees with the United States and *amici* America's Health Insurance Plans and the Blue Cross Blue Shield Association (collectively, the "Health Insurance Industry") that the insurance market reforms that led to the enactment of the individual mandate (and without which it would not have been enacted or function properly) are so inextricably entwined with it as to be inseverable from an invalidated individual mandate. In view of the extensive briefing received by the Court in these cases, the Council largely relies on the brief submitted by the Health Insurance Industry in support of that argument. *See* Point II below.

Second, the Council contends that the employer mandate is also inseverable from the individual mandate, as the former could not function as Congress intended or advance the objectives for which it was enacted if the latter were invalidated. The comprehensive and reticulated coverage scheme promulgated in Subtitle F would be disrupted in the absence of the individual mandate, skewing the shared responsibility paradigm upon which reform is built. *See* Point III below.

The Congressional record extensively documents Congress's objective of achieving near-universal health coverage through a system of shared responsibility. *See, e.g.*, Congressman Stark, co-sponsor of House Bill 3200, discussing issues prior to House vote on the ACA: "The bill guarantees health coverage to 96 percent of Americans. It's fully paid for. People who like their coverage indeed can keep it. It reforms health insurance regulation and *requires shared responsibility by individuals, businesses, and government.*" 155 Cong. Rec. H12856 (daily ed. Nov. 7, 2009) (emphasis added).[3] Both the text and statutory structure of the employer mandate show in various ways that the employer mandate was not simply a free-standing add-on to a long list of provisions in the law, but inextricably entwined with the individual mandate, incapable of functioning as Congress intended in its absence.

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[3] *See also* Senator Dodd, discussing issues prior to vote on HR 3200: "In the United States of America, we believe in shared risk and shared responsibility. Our bill, if signed into law, lowers costs for everyone by ensuring that everyone is insured. The bigger the pool, obviously the broader the risk and the lower the cost. In return, our bill asks individuals, employers, the Federal Government, all of us to share responsibility . . . ." 155 Cong. Rec. S7941 (daily ed. July 22, 2009); Congresswoman Pingree, discussing HR 3200: "The plan that has just been released has a shared responsibility from employers and individuals alike. It has real components to control costs." 155 Cong. Rec. H7132 (daily ed. June 23, 2009); Congresswoman Schwartz, co-sponsor of House Bill 3590 which became law: "We also think that this is a shared responsibility. I certainly do. This is something that we're asking individuals to take some responsibility, employers to take some responsibility, we're asking insurance companies, and many of them are stepping up to the plate saying, We can do this." 155 Cong. Rec. H6145 (daily ed. June 3, 2009).

ARGUMENT

I. SEVERABILITY TURNS ON WHETHER THE REMAINDER OF A STATUTE WOULD FUNCTION AS CONGRESS INTENDED ABSENT THE OFFENDING PROVISION

The touchstone of severability analysis is legislative intent. *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). Before severing an unconstitutional section or provision from a statute, a court must ask: "Would the legislature have preferred what is left of its statute to no statute at all?" *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006). Because the unconstitutionality of a part of an Act does not necessarily undercut the validity of its remaining provisions, the "normal rule" is "that partial, rather than facial, invalidation is the required course." *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)). However, only by examining the structure and aims of the law can a court discern what Congress would have chosen to do in the absence of the offending provision.

The threshold question is whether Congress directly addressed the question of severability in the statutory text itself. When Congress includes a severability clause in a piece of legislation, a presumption arises that portions of the legislation are severable. Omission of such a clause, however, does not invoke the opposite presumption. *Alaska Airlines v. Brock*, 480 U.S. 678, 686 (1987) ("In the absence of a severability clause . . . Congress's silence is just that—silence."). Apart from such clauses, the Court has also looked to "structure and purpose" as primary indicators of legislative "severability intention." *Denver Area Educ. Telecomms. Consortium, Inc. v. FCC*, 518 U.S. 727, 767 (1996).

Separately, Congressional intent concerning severability may be inferred from the ability of the remaining provisions of the statute to function on their own. A statute will be struck down in its entirety if, after the unconstitutional part is severed, the remainder is "incapable of functioning independently." *Alaska Airlines*, 480 U.S. at 684. Not only must a statute function after partial invalidation—it must do so in a "*manner* consistent with the intent of Congress." *Id.* at 685 (emphasis in original). That is, what remains must be "consistent with Congress's basic objectives in enacting the statute." *United States v. Booker*, 543 U.S. 220, 259 (2005) (citing *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984)).

In the context of a "highly complex statute" with "interrelated provisions" that may affect one another in subtle ways—such as the ACA—the Court has expressed the need for caution before severing individual provisions. *See, e.g., Booker*, 543 U.S. at 248. By contrast, in cases where the Court has endorsed severance, it has emphasized the discrete, limited effect of the portions held invalid. *See Denver Area Educ. Telecomms. Consortium*, 518 U.S. at 767-8. The more interrelated the various provisions of a regulatory scheme, the more a holding of inseverability may be necessary because of their mutual "interdependence." *Carter v. Carter Coal Co.*, 298 U.S. at 315. As the Court has held, where severance would require it to "write words into the statute" on the one hand or to "leave gaping loop-holes" on the other, or to foresee "which of many different possible ways the legislature might respond to the constitutional objections" found, prudence counsels against severance. *Randall v. Sorrell*, 548 U.S. 230, 262 (2006).

II. THE INDIVIDUAL MANDATE CANNOT BE SEVERED FROM THE ACT'S PRINCIPAL MARKET REFORM PROVISIONS

For the reasons set forth by the Health Insurance Industry—and by the United States as respondent—the market reform provisions of the ACA are not severable from the minimum coverage requirement (the "individual mandate").

The insurance market reforms of the ACA (guaranteed issue, prohibitions on preexisting condition exclusions or waiting periods, ban on coverage eligibility rules based on health-related factors, and the adjusted community rating system) were enacted along with the individual mandate as a single package, and for a simple reason: Congress concluded, based on extensive evidence, much of it canvassed by the Health Insurance Industry *amicus* brief, that the desired insurance market reforms were unworkable without an individual mandate. That was the lesson gleaned from the experience of various states where market reforms without an individual mandate had been tried and failed.

The individual mandate was not enacted for its own abstract value, but in order to make workable the insurance market reforms that were the central goal, because all the evidence showed that they could not function successfully absent the broader market participation that the individual mandate would supply.

To avoid burdening the Court with repetitive briefing, the Council relies for this argument on the brief of the Health Insurance Industry.

III. THE INDIVIDUAL MANDATE CANNOT BE SEVERED FROM THE EMPLOYER MANDATE

Congress expressly stated in § 1501(a)(2)(D) of the ACA that the individual mandate "achieves near-universal coverage *by building upon* and strengthening the private employer-based health insurance system . . . ." (emphasis added). As such, the private employer-based health insurance system serves to support the individual mandate.

With that in mind, Congress crafted a comprehensive and reticulated coverage scheme based on the concept of shared responsibility, a concept that appears throughout the Congressional record.[4] The very structure of Subsection F of the ACA reveals Congress's intent that the employer mandate function to support the individual mandate by way of a shared responsibility model. Finally, the manner in which the employer responsibility provisions would malfunction in the absence of the individual mandate and related individual-market reforms is yet another indicator of Congress's intent that the employer responsibility provisions work with the individual mandate and related individual-market reforms, serving little function in their absence.

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[4] *See, e.g.*, 155 Cong. Rec. H12856 (daily ed. Nov. 7, 2009) (statement of Rep. Stark); 155 Cong. Rec. S7941 (daily ed. July 22, 2009) (statement of Sen. Dodd); 155 Cong. Rec. H7132 (daily ed. June 23, 2009) (statement of Rep. Pingree); 155 Cong. Rec. H6145 (daily ed. June 3, 2009) (statement of Rep. Schwartz).

A. Overview Of The Employer Mandate

The Act's employer responsibility provisions (also referred to as the "employer mandate") are located in Part II of Subtitle F of the ACA, §§ 1511-1515, which sets forth a number of rules affecting employers, including notice, shared payment, and other coverage obligations. Taken together, these rules establish the structure meant to support the individual mandate vis-à-vis the private employer-provided health system.

1. Employer Payment Responsibility.

The core of the employer responsibility provisions under the ACA is an obligation for an employer to either (1) offer its full-time employees the ability to access minimum essential coverage under an eligible employer-sponsored plan or (2) make so-called shared responsibility payments to the federal government to the extent the employer elects (a) not to offer coverage at all or (b) to provide coverage deemed inadequate under the Act. ACA § 1513. For this purpose, "minimum essential coverage" is insurance coverage offered through a group health plan, a governmental plan, or any other plan or coverage offered in the small or large group market within a State.

ACA § 1501(b). It should be noted that it is ultimately the employees' responsibility to obtain minimum essential coverage. *Id.* In that respect, the employer responsibility provisions of the ACA are meant to support individual employees in their quest to fulfill their individual mandate under the ACA.

Failure to offer such coverage potentially subjects the employer to one of two tax penalties.

First, an employer that fails to offer *any* health insurance coverage is subject to a penalty if at least one full-time employee receives a federal premium tax credit or cost-sharing reduction and is covered under a public exchange plan. ACA § 1513. Put differently, so long as at least one full-time employee is required to turn to a state plan in order to meet his individual mandate obligation and receives a federal premium tax credit, the employer must pay the penalty. That penalty is $167 per month ($2,000 annually) multiplied by the number of full-time employees, minus the first thirty. Pub. L. No. 111-152, 124 Stat. 1029 § 1003.

Second, an employer fails to offer *adequate* coverage if the insurance it makes available does not satisfy either specified "minimum value" or "affordability" standards. Minimum value is defined as an insurance plan that is expected to pay 60% of covered medical expenses across a typical population, with the remaining 40% to be paid by the enrollees through the plan's cost-sharing requirements.[5] ACA § 1401(a). Affordability means that the cost of the coverage cannot exceed 9.5% of the employee's household income. *Id.*

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[5] The Act refers to this metric as "actuarial value." ACA § 1302(d). Actuarial value consolidates a plan's various cost-sharing mechanisms, such as deductibles, coinsurance, and copayments,

Employers that do not offer adequate coverage are subject to a penalty of $250 per month ($3,000 annually) for each full-time employee who is forced to obtain insurance on the open market. In the language of the Act, any employee who receives a federal premium tax credit or cost-sharing reduction and who is covered under a public exchange plan in the course of meeting his or her individual mandate obligation triggers the employer penalty. The penalty for inadequate coverage, however, cannot exceed the penalty that would apply had the employer offered no coverage.[6]

The minimum value standard itself illustrates the inexorably entwined nature of the individual mandate and the employer mandate, as the requisite level of coverage (60%) assumes that an employee's health care expenses will be borne partly by the employer-provided plan and partly by the employee himself (through co-pays, deductibles, or other individual arrangements). Also, the 60% standard under the employer responsibility provisions is equivalent to the actuarial value of a "bronze" plan that will be offered through the state exchanges. A bronze-level plan represents "minimum essential coverage," which satisfies a consumer's requirements under the individual mandate.

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into a single measure that allows consumers to evaluate the plan's overall financial protection.

[6] Because the shared payment penalty formula for the failure to provide adequate coverage uses a figure of $3,000, whereas the formula for failing to provide any coverage uses a figure of $2,000, absent this rule, an employer who provides coverage deemed inadequate could conceivably pay more in shared payment penalties than an employer who provides no coverage.

2. Other Employer Responsibilities.

The employer mandate places other obligations on employers. An employer with over 200 full-time employees is required to enroll its full-time employees automatically in coverage offered under the employer's health plan, if any. ACA § 1511. All employers are required to provide to each of their employees at the time of hiring (or with respect to current employees, not later than March 1, 2013) written notice informing the employee of the existence of a state exchange, including a description of the services provided by such state exchange (the "notice" requirement). ACA § 1512. If the employer's group health plan fails to provide coverage that meets the minimum value and affordability standards, the notice must also state that the employee may be eligible for a premium tax credit and a cost sharing payment if the employee purchases coverage through the exchange. *Id.*

Additionally, employers with more than 50 full-time employees or those who otherwise offer coverage to their employees must report certain aspects of the coverage to the federal government (the "reporting" requirement) as well as notice to employees regarding the same. ACA § 1514. Finally, an employer may make coverage offered under a state exchange available for purchase by its employees through the employer's cafeteria plan.[7] ACA § 1515.

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[7] A "cafeteria plan" is generally an employer-provided plan under which an employee may contribute a portion of his pretax income towards the purchase of various benefits offered under the plan's menu, such as medical insurance and life insurance. 26 U.S.C. § 125.

B. The Structure Of The Statute Evidences Congress's Intent To Implement A Comprehensive Coverage Scheme Premised On Shared Responsibility.

The text and structure of Subtitle F demonstrate that Congress intended both the individual and employer responsibility provisions of the ACA to operate as one comprehensive coverage scheme, built upon a foundation of shared responsibility between employees and employers.

Subtitle F is called "Shared Responsibility for Health Care." Its two parts, which appear side by side, are titled "Individual Responsibility," §§ 1501-02, and "Employer Responsibilities," §§ 1511-15. That structure plainly reflects the Congressional understanding that the two sets of provisions were meant to operate hand in hand. *See Carter v. Carter Coal Co.*, 298 U.S. 238, 314 (1936) (concluding that provisions of a comparably complex statute were inseverable).

Indeed, the very text of the employer mandate is built on, and cross-references, definitions that are crucial to the individual mandate. The basic responsibility expressed in the individual mandate is for a person to maintain "minimum essential coverage" for himself as well as for his dependents. ACA § 1501(b). Significantly, that term is defined within the individual responsibility provisions of the Act and is the foundation term for many of the Act's employer responsibility provisions. *See, e.g.,* ACA § 1513(a) (assessing shared payment penalty against employer who fails to provide its full-time employees an opportunity to enroll in "minimum essential coverage" offered under an "eligible employer sponsored plan") (citing ACA

§ 1501(b)); ACA § 1513(a) (assessing shared payment penalty against employer who fails to provide affordable or minimum value "minimum essential coverage" to its employees through an "eligible employer sponsored plan") (citing ACA § 1501(b)); ACA § 1513(a) (assessing penalty against employers who require an extended waiting period to enroll in "minimum essential coverage" through its "eligible employer sponsored plan") (citing ACA § 1501(b)); ACA § 1514(a) (requiring employers with 50 or more full-time employees to file an annual return with the federal government containing, among other information, a certification as to whether the employer provides "minimum essential coverage" to its employees through an "eligible employer sponsored plan") (citing ACA § 1501(b)).[8]

As *Carter* instructs, "[t]he statutory mandate for a code upheld by two legs at once suggests the improbability that Congress would have assented to a code supported by only one." 298 U.S. at 314. Subtitle F sets forth the two legs Congress intended to serve as the basis for affording an employee the opportunity to satisfy the individual mandate vis-à-vis the private employer-provided health insurance system; namely, Part I, "Individual Responsibility," §§ 1501-02, and Part II, "Employer Responsibilities" §§ 1511-15. The structure of Subtitle F thus suggests that Congress would not have assented to the removal of the individual mandate without also removing the employer responsibility provisions.

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[8] ACA § 1514(a) acknowledges that much of the information required to be reported under this section is also required to be reported under ACA § 1501(b), which is housed within the individual responsibility provision of the Act, and permits the oversight agency to adopt rules consolidating the reporting requirements.

C. The Employer Responsibility Provisions Of The Act Would Not Function As Congress Intended In The Absence Of The Individual Responsibility And Individual-Market Reform Provisions Of The ACA.

If the individual mandate and its associated insurance market reforms were invalidated, the employer responsibility provisions of the ACA would not serve their stated purpose or function in the manner that was intended by Congress. *Alaska Airlines*, 480 U.S. at 684. The reason is straightforward: the employer responsibility provisions serve as a base to support the individual mandate through the private employer-provided insurance market. As such, Congressional intent in implementing the employer responsibility provisions of the ACA would be frustrated without the individual mandate and related individual-market reforms because the employer responsibility provisions would lose their purpose. Indeed, the manner in which the employer responsibility provisions would function (or malfunction) in the absence of the individual mandate and related individual-market reforms demonstrates this result.

1. Operation of the Shared Payment Penalties.

As mentioned above, the ACA assesses a shared payment penalty against an employer who does not provide any coverage to its employees. That penalty is triggered if at least one full-time employee receives federally subsidized coverage under a state exchange. As with the other employer responsibility provisions under the Act, this formula makes sense under a system of universal coverage under the state exchanges, but not otherwise. That is, it can be assumed that a large number of employees who are not covered under an employer-provided plan will receive subsidized coverage under a state exchange, particularly in certain industries.[9] As such, the rule assesses a penalty calculated over the employer's entire employee base (less 30) in order to assure that the employer meets its shared responsibility under the Act.

However, a large number of employees would no longer be eligible for federally subsidized coverage under the state exchanges in a system that lacked the individual mandate and related individual-market reforms because the market reforms make it possible for individuals to obtain coverage who otherwise could not.[10] Moreover, absent the individual mandate, it may be assumed that there will be a certain number of employees who leave the system by choice. One result of striking the individual mandate and its related individual-market reforms, then, is that the federal government would pay considerably less in federal subsidies through the state exchanges due to there being fewer employees in the system. In the absence of the individual mandate, the employer responsibility provisions of the ACA would continue to assess a penalty against employers as though state-based coverage was being fully utilized by employees, even though a number of employees would be precluded from such coverage due to the absence of the individual-market reforms and others would opt out of the system by choice.

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[9] *See* Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population*, Emp. Benefit Res. Inst. No. 362 at 15 (Sept. 2011). "Workers employed in agriculture, forestry, fishing, mining and construction were disproportionately more likely to be uninsured in 2010."

[10] In a series of reports examining the impact full repeal of the ACA would have on congressional districts and large metropolitan areas, the House Committee on Energy and Commerce highlighted the fact that removal of market reforms could affect large numbers of individuals, particularly those with preexisting conditions, who currently lack insurance coverage and who would lose the ability to obtain coverage in individual markets. Each of the thirty metro area reports includes the projected number of residents (in thousands) who fit into this group. Letter from Rep. Henry A. Waxman, Ranking Member of the House

The point of the penalty is to require the employer to offset costs to the federal government for premium subsidies it provides to qualified individuals who obtain coverage in a health insurance exchange rather than through an employer-sponsored health plan.[11] It was not

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Comm. on Energy and Commerce, and Rep. Frank Pallone, to the House of Representatives (Jan. 18, 2011), *available at* http://democrats.energycommerce.house.gov/index. php?q=news/impact-of-repealing-health-care-reform.

[11] According to Douglas E. Elmendorf, Director of the Congressional Budget Office: "[Federal] costs will be partly offset by higher revenues . . . from four sources: an increase in net revenues from the excise tax on high-premium insurance plans, totaling $87 billion; penalty payments by uninsured individuals, increasing revenues by $34 billion; penalty payments by employers, increasing revenues by $81 billion; and other budgetary effects, mostly on tax revenues, associated with shifts in the mix of taxable and nontaxable compensation resulting from

part of Congress's intention to direct employers to pay a "shared responsibility" payment and, thus, reimburse the federal government with respect to individuals who cannot receive the intended federal subsidy that was an integral part of the intended arrangement.

The same is true of the other shared payment penalty assessed against an employer who offers inadequate coverage. This penalty is only triggered with respect to employees who receive federally-subsidized coverage through a state exchange. In the absence of the individual responsibility and individual-market reform provisions, however, it is almost a certainty that those employees who were uninsurable in the individual market prior to passage of the ACA (because of poor health or pre-existing conditions) would once again find themselves unable to obtain coverage in the individual market by way of the state exchanges.

Consequently, the only penalties employers would pay if they provide coverage that failed to meet the minimum affordability and value standards would be in regard to the very employees who were already capable of obtaining their own insurance. Thus, absent the individual mandate and related individual-market reforms, Congress's overall coverage scheme would leave to the sideline those whom Congress most wanted to incorporate into the system,

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changes in employment-based health insurance coverage, which will decrease deficits by $113 billion." *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010: Testimony Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 112th Cong. 18 (2011) while assisting individuals who already receive its benefits.[12]

As explained in *Alaska Airlines*, the test for severability is not whether the statute would continue to function in some fashion absent the offending provision, but whether the remaining provisions would function in the manner that Congress intended. 480 U.S. at 685. Judged by that standard, the penalty provision for failure to meet the ACA's minimum value and affordability standards would no longer work as Congress intended in the absence of the individual mandate and individual market reforms.

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[12] The Congressional Record extensively documents Congress's focus on the group of people who would otherwise be unable to obtain affordable insurance or any insurance at all without market reforms. *See, e.g.*, Senator Rockefeller discussing the focus of one of the initial health care bills introduced, portions of which were eventually included in ACA: "Unfortunately, preexisting condition exclusions are often a barrier for individuals seeking access to comprehensive health insurance coverage." 155 Cong. Rec. S3183 (daily ed. Mar. 17, 2009) (statement of Sen. Rockefeller); Senator Kerry discussing the purpose of ACA: "People who are criticizing this bill ought to take a look at what it does . . . . This bill will prohibit companies from denying insurance to people because they have a preexisting condition . . . . Uninsured Americans with a pre-existing condition can have access to an immediate insurance program and help them avoid medical bankruptcy." 155 Cong. Rec. S13449-50 (daily ed. Dec. 18, 2009) (statement of Sen. Kerry); "We are against preexisting conditions, making sure that any child doesn't get denied coverage because of a preexisting condition." 155 Cong. Rec. H1438 (daily ed. Mar. 15, 2010) (statement of Congressman T. Ryan).

In sum, Congress would not have sought to impose the shared payment penalties if it could not create the intended benefits for the uninsured or difficult-to-insure among the American workforce and their families. Accordingly, that mandate should rise or fall along with the individual mandate and the corresponding market reforms.

2. Operation of Other Shared Employer Responsibilities.

Although an employer is required to offer its employees "an opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan," it is the employees who are ultimately responsible to secure minimum essential health coverage. *See, e.g.*, ACA § 1513(a); § 1501(b). The employer responsibility provisions are meant to assist employees in meeting the individual mandate under the Act. If the individual mandate were invalidated, many aspects of the employer responsibilities would become unnecessary, or even counter-productive.

For example, the notice provisions would serve little purpose in the absence of the individual mandate. These notice requirements are meant to arm an employee with the relevant information necessary to make an informed choice between electing coverage under his employer-sponsored plan or through a state exchange. But as discussed above, absent the individual mandate and related individual-market reforms, many employees would not have an actual choice between types of plans; indeed, they might not be eligible for either. Nor would those uninsurable employees be eligible for a premium tax credit and a cost sharing payment by the federal government. As such, requiring employers to provide such a notice would be pointless. Indeed, it might actually be counter-productive, as it would likely confuse and mislead employees into assuming they have eligibility when they do not.

Similarly, § 1514 of the ACA requires employers to report to the federal government, among other information, whether it offers a plan that meets minimum essential coverage. The employer must also report to the federal government regarding each employee who is eligible for coverage under its employer-sponsored plan, and provide a notice to these employees regarding the information being reported to the government. *Id.* These rules would lose their purpose absent the individual mandate because there would be no requirement that an individual acquire minimum essential coverage at all. It would be an odd result to continue to require an employer to report whether it provides its employees the opportunity to enroll in minimum essential coverage under a system where employees are no longer required to obtain such coverage. Moreover, it would be too burdensome and intrusive to continue to require an employer to forward the names and other information regarding its employees to the federal government after that information loses its value to the government.

In the end, the reporting requirements under § 1514 lose their purpose absent the individual mandate. This loss of purpose is another indication that Congress intended the individual mandate and the employer responsibility provisions of the ACA to function as a unitary coverage scheme meant to operate within the private employer-provided insurance system.

Striking the individual mandate would undercut another feature of the employer mandate. The ACA specifically authorizes employers to meet their obligations through the offering of a cafeteria plan. § 1515. This option is important because it provides a mechanism for employees to purchase group health coverage on a pretax basis by way of payroll reduction. Under governing tax law, employer-sponsored cafeteria plans may not discriminate in favor of highly compensated employees ("HCEs"). 26 U.S.C. § 125.

In a system of universal availability of exchange-based coverage, the discrimination issue is largely irrelevant, because all employees will be eligible to participate in and benefit under the cafeteria plan. But, in a system where many employees will not qualify for coverage—*i.e.*, a system absent the individual mandate and related individual-market reforms—discrimination testing is back on the table. The inability of individuals to obtain insurance through the exchange, and therefore participate in the cafeteria plan, could result in discrimination in violation of 26 U.S.C. § 125. Any such discrimination would be caused by the uninsurability of employees as opposed to any action taken by the employer in implementing its cafeteria plan.

However, employers have no way of identifying which of their employees will or will not be eligible for state exchange-coverage in the absence of the individual mandate and related individual-market reforms and, thus, eligible to participate in the employer-sponsored cafeteria plan. Employers will not know whether their employees are or are not insurable through the state exchanges. This uncertainty will likely cause reluctance by employers to utilize a cafeteria plan strategy, because there will be a lack of certainty as to the tax consequences of such strategy. This result is yet another indication of the entwined nature of the individual mandate, the individual-market reforms, and the employer responsibility provisions of the ACA.

These are but a few examples, in addition to the shared payment penalty examples above, demonstrating the widening impact that elimination of the individual mandate and related individual market reforms would create with respect to the functioning of the employer responsibility provisions of the ACA and its ability to serve the underlying goals of the statute. Surely other unforeseeable consequences would result from the excision of the individual mandate and related individual market reforms from the Act unless the employer mandate were also invalidated. Inasmuch as the Court cannot possibly foresee every consequence, and is not in a position to determine how Congress would have wanted to address such unexpected developments arising from striking the individual mandate, prudence counsels against severing the employer responsibility provisions from the individual mandate provisions of the ACA. *Randall v. Sorrell*, 548 U.S. 230, 262 (2006).

CONCLUSION

For the foregoing reasons, if the Court invalidates the individual mandate, the Eleventh Circuit's severability judgment should be vacated, and both the ACA's market reform provisions (concerning guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating provisions) and the employer mandate should be invalidated as well.

January 27, 2012

Respectfully submitted,

JAMES A. KLEIN
President
KATHRYN M. WILBER
Senior Counsel,
Health Policy
AMERICAN BENEFITS COUNCIL
1501 M Street, N.W.
Suite 600
Washington, DC 20005

JAMES R. NAPOLI
Counsel of Record
PROSKAUER ROSE LLP
1001 Pennsylvania Ave., NW
Suite 400, South
Washington, DC 20004
(202) 416-5862
jnapoli@proskauer.com

MARK D. HARRIS
CHARLES S. SIMS
PROSKAUER ROSE LLP
11 Times Square
New York, NY 10036

AMICUS CURIAE BRIEF

Nos. 11-393 & 11-400

In The Supreme Court of the United States

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NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, *et al.*,

Petitioners,

vs.

KATHLEEN SEBELIUS, *et al.*,

Respondents.

◆

STATE OF FLORIDA, *et al.*,

Petitioners,

vs.

UNITED STATES DEPARTMENT OF
HEALTH & HUMAN SERVICES, *et al.*,

Respondents.

◆

On Writs Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

◆

AMICI CURIAE BRIEF OF THE AMERICAN CENTER FOR LAW & JUSTICE, 117 MEMBERS OF THE UNITED STATES CONGRESS, AND MORE THAN 103,000 SUPPORTERS OF THE ACLJ IN SUPPORT OF PETITIONERS AND URGING REVERSAL ON THE SEVERABILITY ISSUE

◆

JAY ALAN SEKULOW
Counsel of Record
STUART J. ROTH
COLBY M. MAY
JAMES M. HENDERSON SR.
WALTER M. WEBER
EDWARD L. WHITE III
ERIK M. ZIMMERMAN
MILES L. TERRY

AMERICAN CENTER FOR LAW & JUSTICE
[redacted]

January 6, 2012

Counsel for Amici Curiae

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

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INTEREST OF THE AMICI CURIAE

Amicus curiae, the American Center for Law & Justice ("ACLJ"), is an organization dedicated to defending constitutional liberties secured by law.[1] ACLJ attorneys have argued before this Court and other federal and state courts in numerous cases involving constitutional issues. *E.g.*, *Pleasant Grove City v. Summum*, 555 U.S. 460 (2009); *McConnell v. FEC*, 540 U.S. 93 (2003). ACLJ attorneys also have participated as amicus curiae in numerous cases involving constitutional issues before this Court and lower federal courts. *E.g.*, *FEC v. Wisconsin Right to Life, Inc.*, 551 U.S. 449 (2007); *Van Orden v. Perry*, 545 U.S. 677 (2005).

The ACLJ has been active in litigation concerning the Patient Protection and Affordable Care Act of 2010 ("ACA" or "Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010), Pub. L. No. 111-152, 124 Stat. 1029 (2010), in particular, with regard to the "individual mandate" provision, 26 U.S.C. § 5000A, which requires millions of Americans to purchase and maintain Federal Government-approved health insurance from a private company for the remainder of their lives or be penalized annually. The ACLJ has filed amici curiae briefs in support of the following challenges to the

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[1] No counsel for a party authored this brief in whole or in part. No person or entity aside from amici curiae, their members, and their counsel made a monetary contribution to the preparation or submission of this brief. The parties have filed notices with this Court consenting to the filing of amicus curiae briefs.

ACA: *Virginia v. Sebelius*, No. 3:10-CV-188-HEH (E.D. Va.), and Nos. 11-1057, 11-1058 (4th Cir.); *TMLC v. Obama*, No. 10-2388 (6th Cir.); and *Florida v. United States Dep't of Health & Human Servs.*, No. 3:10-CV-91-RV-EMT (N.D. Fla.), Nos. 11-11021-HH, 11-11067-HH (11th Cir.), and No. 11-400 (U.S.).

Additionally, the ACLJ represents the plaintiffs in a challenge to the individual mandate: *Mead v. Holder*, No. 1:10-CV-00950-GK (D.D.C.), *appeal sub. nom. Seven-Sky v. Holder*, No. 11-5047 (D.C. Cir.). The ACLJ has recently filed a petition for a writ of certiorari in *Seven-Sky v. Holder*, No. 11-679 (U.S. Nov. 30, 2011). Accordingly, the ACLJ has an interest that may be affected by the instant case.

This brief is also filed on behalf of United States Representatives Paul Broun, Robert Aderholt, Todd Akin, Rodney Alexander, Mark Amodei, Steve Austria, Michele Bachmann, Spencer Bachus, Lou Barletta, Roscoe Bartlett, Joe Barton, Rob Bishop, Diane Black, Marsha Blackburn, Charles Boustany, Kevin Brady, Mo Brooks, Larry Bucshon, Michael Burgess, Dan Burton, Francisco "Quico" Canseco, Eric Cantor, Steve Chabot, Howard Coble, Mike Coffman, Tom Cole, Mike Conaway, Chip Cravaack, Geoff Davis, Scott DesJarlais, Jeff Duncan, Blake Farenthold, Stephen Fincher, Chuck Fleischmann, John Fleming, Bill Flores, Randy Forbes, Virginia Foxx, Trent Franks, Cory Gardner, Scott Garrett, Bob Gibbs, Phil Gingrey, Louie Gohmert, Bob Goodlatte, Tom Graves, Tim Griffin, Michael Grimm, Ralph Hall, Gregg Harper, Andy Harris, Vicky Hartzler, Jeb Hensarling, Wally Herger, Tim

Huelskamp, Bill Huizenga, Randy Hultgren, Lynn Jenkins, Bill Johnson, Walter Jones, Jim Jordan, Mike Kelly, Steve King, Adam Kinzinger, John Kline, Raul Labrador, Doug Lamborn, Jeff Landry, James Lankford, Robert Latta, Billy Long, Blaine Luetkemeyer, Cynthia Lummis, Dan Lungren, Connie Mack, Donald Manzullo, Kenny Marchant, Kevin McCarthy, Michael McCaul, Tom McClintock, Thaddeus McCotter, Cathy McMorris Rodgers, Gary Miller, Jeff Miller, Randy Neugebauer, Alan Nunnelee, Pete Olson, Ron Paul, Steve Pearce, Mike Pence, Joe Pitts, Ted Poe, Mike Pompeo, Bill Posey, Tom Price, Ben Quayle, Reid Ribble, Scott Rigell, Phil Roe, Todd Rokita, Dennis Ross, Ed Royce, Steve Scalise, Jean Schmidt, Adrian Smith, Lamar Smith, Marlin Stutzman, Lee Terry, Scott Tipton, Michael Turner, Tim Walberg, Joe Walsh, Daniel Webster, Lynn Westmoreland, Joe Wilson, Rob Woodall, and Don Young, who are 117 members of the United States House of Representatives in the One Hundred Twelfth Congress. In addition, this brief is filed on behalf of more than 103,000 supporters of the ACLJ who specifically requested that they be included in this brief as an expression of support for the ACLJ's efforts to overturn the ACA.

Amici curiae are dedicated to the founding principles of a limited Federal Government and the belief that the Constitution contains meaningful boundaries that Congress may not trespass – no matter how serious the nation's healthcare problems. Amici curiae believe that the Constitution does not empower Congress to require Americans to purchase and maintain health insurance from a private company for the rest of their lives or pay an annual penalty. Amici curiae are deeply troubled by the fundamental alteration to the nature of our federalist system of government that would be required to recognize a novel Congressional power to mandate that citizens buy a product from a private company. Amici curiae urge this Court to rule the individual mandate unconstitutional and to declare the entire ACA invalid, since the unconstitutional individual mandate cannot be severed from the ACA.

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SUMMARY OF THE ARGUMENT

The United States Court of Appeals for the Eleventh Circuit correctly ruled that the individual mandate is unconstitutional because it exceeds Congress's powers under Article I of the United States Constitution. The Eleventh Circuit, however, erred in concluding that the individual mandate can be severed from the remainder of the ACA. The unconstitutional individual mandate is the essential component of the ACA's reforms to the health insurance and health care markets, as the Federal Government has conceded. Congress would not have passed the ACA absent the individual mandate. Without the individual mandate, the ACA's remaining provisions cannot function properly. Thus, the unconstitutional individual mandate is not severable from the ACA, and the entire Act must be invalidated. This Court should reverse the Eleventh Circuit's judgment on the severability issue.

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ARGUMENT

THE UNCONSTITUTIONAL INDIVIDUAL MANDATE CANNOT BE SEVERED FROM THE REST OF THE ACA, AND THE ENTIRE ACA SHOULD BE RULED INVALID.

The Eleventh Circuit correctly held that the individual mandate is unconstitutional. The Eleventh Circuit properly concluded that the Commerce Clause does not give Congress the power to require American citizens to purchase a product from a private company for the remainder of their lives or be penalized annually, and the court also properly noted that there would be no judicially-administrable limits to Congress's power that would prevent Congress from mandating numerous other purchases from private companies if the Act's individual mandate were upheld. *Florida v. United States Dep't of Health & Human Servs.*, 648 F.3d 1235, 1311-13 (11th Cir. 2011).

Regarding severability, however, the Eleventh Circuit incorrectly reversed the district court's well-reasoned determination that the individual mandate cannot be severed from the ACA and, as such, the entire Act is invalid. *Florida v. United States Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1299-1305 (N.D. Fla. 2011). The Eleventh Circuit determined instead that *only* the unconstitutional individual mandate may be severed from the ACA. *Florida*, 648 F.3d at 1320-28. In that regard, the Eleventh Circuit erred, and its judgment on the severability issue should be reversed.

"The inquiry into whether a statute is severable is essentially an inquiry into legislative intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). "Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently." *Alaska Airlines v. Brock*, 480 U.S. 678, 684 (1987). A court must ask "whether [after removing the invalid provision] the [remaining] statute will function in a manner consistent with the intent of Congress." *Id.* at 685 (original emphasis omitted).

Two factors demonstrate that Congress did not intend the individual mandate to be severable. First, the Affordable Health Care for America Act (H.R. 3962), which the House approved on November 7, 2009, contained an individual mandate section as well as a severability provision.[3] H.R. 3962's severability provision, however, was not included in the final version of the ACA. Congress's *conscious* rejection of a severability clause in the ACA is strong evidence that Congress did not intend for the statute's individual provisions to be severable.

Second, Congress would not intend for a provision to be severable if severing it would allow an inoperable or counterproductive regulatory scheme to stand. *Alaska Airlines*, 480 U.S. at 684; *accord Free Enter. Fund. v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161-62 (2010). The Federal Government has conceded that the individual mandate is essential to the ACA. As such, without the individual mandate, the Act's remaining portions cannot function "in a manner consistent with the intent of Congress." *See Alaska Airlines*, 480 U.S. at 685. For example, in *Mead v. Holder*, No. 1:10-CV-950-GK (D.D.C.), the Federal Government asserted that the individual mandate is essential to the workings of the ACA's reforms to the health insurance and health care markets. The Federal Government stated

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[3] Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 255 (2009), *available at Bill Summary & Status*, http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.3962: (click on "Text of Legislation," then the link for "Affordable Health Care for America Act (Engrossed in House [Passed House]-EH)").

- that the ACA's "*reforms of the interstate insurance market . . . could not function effectively without the* [*individual mandate*] *provision*." Memorandum in Support of the Defendants' Motion to Dismiss, *Mead v. Holder*, No. 1:10-CV-950-GK (D.D.C.), Doc. 15-1 at 22 (filed on Aug. 20, 2010) (available on PACER) (emphasis added);
- that the individual mandate is "*an 'essential' part of the Act's larger regulatory scheme for the interstate health care market*," *id.* (emphasis added);
- that Congress found the individual mandate "*not only is adapted to, but is 'essential' to, achieving key reforms of the interstate health care and health insurance markets*," *id.* at 24 (emphasis added); and

- that "*Congress determined*, also with substantial reason, *that* [*the individual mandate*] *provision was essential to its comprehensive scheme of reform. Congress acted well within its authority to integrate the provision into the interrelated revenue and spending provisions of the Act.*" *Id.* at 31 (emphasis added).

The Federal Government made similar concessions in other challenges to the ACA concerning the importance of the individual mandate to the overall Act. In the United States District Court for the Eastern District of Virginia, the Federal Government maintained that the individual mandate "*is essential to the comprehensive regulation Congress enacted.*" Memorandum in Support of Defendants' Motion for Summary Judgment, *Virginia v. Sebelius*, No. 3:10-CV-188-HEH (E.D. Va.), Doc. 91 at 26 (filed on Sept. 3, 2010) (available on PACER) (emphasis added). And, in the instant case, the Federal Government asserted in the United States District Court for the Northern District of Florida that "*Congress found that* [*the individual mandate*] *'is an essential part of this larger regulation of economic activity,' and that its absence 'would undercut Federal regulation of the health insurance market.'*" Memorandum in Support of Defendants' Motion for Summary Judgment, *Florida v. United States Dep't of Health & Human Servs.*, No. 3:10-CV-91-RV-EMT (N.D. Fla.), Doc. 82-1 at 11, 20 (filed on Nov. 4, 2010) (available on PACER) (emphasis added) (quoting 42 U.S.C. § 18091(2)(H)).

In addition to its broader concessions noted in the previous paragraphs, the Federal Government has specifically conceded that the individual mandate is essential to two particular provisions of the ACA: the guaranteed issue provision, 42 U.S.C. § 300gg-1 (effective Jan. 1, 2014), and the prohibition on preexisting condition exclusions, 42 U.S.C. § 300gg-3 (effective Jan. 1, 2014). The United States District Court for the Middle District of Pennsylvania accepted this concession and ruled that, not only is the individual mandate unconstitutional, but the individual mandate must be severed from the ACA along with the guaranteed issue and preexisting conditions provisions. *Goudy-Bachman v. United States Dep't of Health & Human Servs.*, 2011 U.S. Dist. LEXIS 102897 at *64-73 (M.D. Pa. Sept. 13, 2011); *id.* at *68 (explaining that the Federal Government conceded that the guaranteed issue and preexisting conditions provisions are "'absolutely intertwined'" with the individual mandate and "must be severed should the individual mandate provision be severed").

In sum, as the Federal Government has conceded, the individual mandate is essential to the overall operation of the ACA. It follows that Congress could not have intended the individual mandate to be severable from the rest of the ACA; the ACA's reforms to the health care and health insurance markets could not function without the individual mandate. These observations, along with the fact that Congress deleted a severability provision from an earlier version of the health care reform legislation, lead to one conclusion: the individual mandate is not severable from the ACA's remaining provisions. Accordingly, this Court should rule the entire ACA invalid and reverse the Eleventh Circuit's decision on this point.

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CONCLUSION

The unconstitutional individual mandate is the essential element of the ACA, and the balance of the ACA cannot function independently without the individual mandate. Amici curiae, therefore, respectfully request that this Court reverse the Eleventh Circuit's judgment that the unconstitutional individual mandate can be severed from the rest of the ACA and urge this Court to rule the entire ACA invalid.

Respectfully submitted,

JAY ALAN SEKULOW
Counsel of Record
STUART J. ROTH
COLBY M. MAY
JAMES M. HENDERSON SR.
WALTER M. WEBER
EDWARD L. WHITE III
ERIK M. ZIMMERMAN
MILES L. TERRY
AMERICAN CENTER FOR
LAW & JUSTICE
[redacted]

January 6, 2012

Counsel for Amici Curiae

AMICUS
CURIAE
BRIEF

No. 11-400

IN THE

Supreme Court of the United States

STATES OF FLORIDA, *et al.*
Petitioners,
v.
UNITED STATES DEPT. OF HHS, *et al.*
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

AMICI CURIAE BRIEF OF THE AMERICAN CIVIL RIGHTS UNION AND THE SOCIAL SECURITY INSTITUTE IN SUPPORT OF PETITIONERS ON MEDICAID

SOCIAL SECURITY INSTITUTE
4305 Fauquier Ave.
Suite A
PO Box 216
The Plains, VA 20198
(703) 582-8466

PETER FERRARA
Counsel of Record
AMERICAN CIVIL RIGHTS UNION
310 Cattell Street
Easton, PA 18042
(610) 438-5721
peterferrara@msn.com

Counsel for Amici Curiae American Civil Rights Union and Social Security Institute

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

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INTEREST OF THE *AMICI*[1]

The American Civil Rights Union is a non-partisan, non-profit, 501(c)(3), legal/educational policy organization dedicated to defending all of our constitutional rights, not just those that might be politically correct or fit a particular ideology. It was founded in 1998 by long time policy advisor to President Reagan, and the architect of modern welfare reform, Robert B. Carleson. Carleson served as President Reagan's chief domestic policy advisor on federalism, and originated the concept of ending the federal entitlement to welfare by giving the responsibility for those programs to the states through finite block grants. Since its founding, the ACRU has filed *amicus curiae* briefs on constitutional law issues in cases nationwide.

Those setting the organization's policy as members of the Policy Board are former U.S. Attorney General, Edwin Meese III; former Assistant Attorney General for Civil Rights, William Bradford Reynolds; former Assistant Attorney General for the Office of Legal Counsel, Charles J. Cooper; John M. Olin Distinguished Professor of Economics at George Mason University, Walter E. Williams; former Harvard University Professor, Dr. James Q. Wilson;

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[1] Peter Ferrara authored this brief for the American Civil Rights Union (ACRU). No counsel for either party authored the brief in whole or in part and no one apart from the *amici* made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this brief, and were timely notified.

former Ambassador Curtin Winsor, Jr.; former Assistant Attorney General for Justice Programs, Richard Bender Abell and former Ohio Secretary of State J. Kenneth Blackwell.

The Social Security Institute is a 501(c)(4), non-profit foundation dedicated to reform of the nation's entitlement programs.

This case is of interest to the Amici because we seek to ensure that the Constitutional limits to federal power are fully recognized and enforced. That includes on this issue in particular the Constitutional framework for federalism.

STATEMENT OF THE CASE

Medicaid has been a joint federal/state partnership since its inception in 1965, with each state free to decide whether and when to participate. The federal government has paid for 50% to 83% of total program costs in each state, depending on a statutory formula calculating the federal contribution by state.

Until the passage in 2010 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, (hereafter the "ACA"), the states each enjoyed substantial discretion to decide Medicaid eligibility and scope and duration of coverage. *Alexander v. Choate,* 469 U.S. 287, 303 (1985). That was consistent with state sovereignty and the Constitutional framework of federalism.

At the core of the ACA is the individual mandate, requiring every citizen to obtain health insurance coverage with the benefits and provisions specified by the federal government. The means provided under the ACA for lower income individuals and families to obtain that required coverage is through transformation of the Medicaid program.

Under the ACA, the federal government now imposes Medicaid on the states as a federally defined program to meet the requirements of the individual mandate as specified by the federal government, for the entire below age 65 population with incomes under 138% of the poverty line. That includes mandatory coverage for the first time for all non-elderly childless adults within the income limits. The states consequently no longer have substantial discretion to determine eligibility and scope and duration of coverage for the program within their respective jurisdictions.

The result will be to increase Medicaid enrollment by 24 million additional beneficiaries by 2015,[2] covering nearly 100 million Americans by 2021 according to CBO.[3] That will impose at least another $20 billion to $42 billion in additional costs on the states by the end of the decade, even counting all the federal financing for Medicaid.[4] That does not count the cost of the 18% of the uninsured who are eligible for but not enrolled in Medicaid, who will have to enroll to comply with the individual mandate.[5]

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[2] Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended, April 22, 2010, p. 6, Table 2.

[3] Congressional Budget Office, The Budget and Economic Outlook: Fiscal Years 2011 to 2021, January, 2011, p. 62.

The ACA also imposed an entirely new, inestimable, mandatory obligation on the states, inflicting on the states the responsibility for providing the care and services under Medicaid themselves. ACA, Section 2304. The states are consequently exposed to liability for care demanded beyond what doctors and hospitals are willing to provide. Given the extremely low fees Medicaid pays to doctors and hospitals, that liability is in the twilight zone at least, and potentially out of this world.

The ACA imposes all these new terms on Medicaid as a condition of continued state participation in Medicaid at all. That threatens the states with the loss of all federal Medicaid funds unless they buckle to all of the ACA's new, mandatory expansions of state obligations under Medicaid. Those federal Medicaid funds currently account for more than 40% of all federal funds granted to the states, and 7% of all federal spending, amounting to more than $276 billion in 2011 alone.[6] Even before passage of the ACA, federal and state spending on Medicaid on average amounted to 20% of state total annual budgets.[7]

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[4] Douglas Elmendorf, Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010, Table 2; Kaiser Comm'n on Medicaid and the Uninsured, *Medicaid Coverage & Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* 23 (May 2010).

[5] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* 12 (Dec. 2008).

In Plaintiff Florida, for example, paying the same Medicaid benefits as before the ACA in 2010 without federal funds would have consumed almost two-thirds of Florida's tax revenues for the year. As for the federal claim that Florida could just raise its own taxes to pay those benefits if it doesn't want to comply with the ACA's mandates, the federal government already collects more than $100 billion per year in federal taxes from Florida residents, leaving little or no capacity for further tax increases. Mem. Supp. Pltfs.' Motion Summ. J. 33 [R.E. 493].

But that is not all that the ACA threatens if states do not concede to the ACA's demands. Section 602(a)(3) imposes as a condition of federal funding under Temporary Assistance for Needy Families (TANF) that children served by that program "are eligible for medical assistance under the State [Medicaid] plan."

Indeed, the ACA is designed on the assumption that states will have no real option other than to participate in Medicaid, and kowtow to all of the ACA's impositions. The ACA's individual mandate applies to Medicaid-eligible individuals. But the

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[6] Henry J. Kaiser Found., *Federal and State Share of Medicaid Spending, FY2009* (2010); The President's Budget for Fiscal Year 2012, Historical Tables, Table 8.5.

[7] Nat. Ass'n of State Budget Officers, *2008 State Expenditure Report* (Fall 2009), Table 5.

ACA carefully provides no means for the nation's neediest to obtain the required insurance and comply with the mandate other than through participation in Medicaid.

The ACA does provide for extensive new benefits for the purchase of health insurance for those making up to $88,000 a year to start (4 times the poverty level), climbing to over $100,000 after a few years.[8] But those suffering in poverty, the majority of those eligible for Medicaid, are expressly excluded from these new benefits. Clearly, the ACA is built on the assumption that states have no real choice to provide for these neediest other than through participation in Medicaid.

Soon after passage of the ACA, 25 states joined in this suit asking for a declaratory judgment that the ACA is unconstitutional, in part on the grounds that the ACA's mandatory expansion of Medicaid is unconstitutionally coercive, infringing on state sovereignty and the Constitution's framework of federalism. The District Court denied the federal government's motion to dismiss the Medicaid claim because "If the Supreme Court meant what it said in *Dole* and *Steward Machine*...there is a line somewhere between mere pressure and impermissible coercion." Pet. App. 463a.

But the District Court ultimately granted summary judgment to the federal defendants on the states' coercion claim, on the view that current precedent was insufficient to invalidate spending legislation on these grounds. The court held that "unless and until [this Court] revisit[s] and reconsider[s] its Spending Clause cases....the states have very little recourse to remaining the very junior partner in the [state-federal] partnership." Pet. App. 287a-88a. That is a shortcoming this Court can remedy on this appeal.

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[8] Douglas Holtz-Eakin and Cameron Smith, Labor Markets and Health Care Reform: New Results, American Action Forum, May, 2010

The Eleventh Circuit affirmed this ruling. While recognizing that "[t]o say that the coercion doctrine is not viable or does not exist is to ignore Supreme Court precedent," the court also invited further definition from this Court, saying, "[i]f the government is correct that Congress *should* be able to place any and all conditions it wants on the money it gives to the states, then the Supreme Court must be the one to say it." Pet. App. 59a-60a.

SUMMARY OF ARGUMENT

Under our Constitutional framework of federalism, the states are sovereign entities with their own Constitutionally protected powers which the federal government cannot transgress. Consequently, the federal government does not hold the constitutional power simply to order the states to implement federal policies.

The Founders adopted this policy of federalism and sovereignty of the states in the Constitution as an essential check and balance on the power of the federal government, to preserve liberty.

Moreover, this Court has long recognized under the Coercion Doctrine that just as Congress has no enumerated power to order states to implement federal policies, it may not use its Spending Power to achieve the same result indirectly. As this Court said in *New York v. United States,* 505 U.S. 144 (1992), the touchstone of "permissible method[s] of encouraging a State to conform to federal policy choices" is that "the residents of the State retain the ultimate decision as to whether or not the State will comply." *Id.* at 168. Congress violates state sovereignty and the Constitutional framework of federalism when it "issu[es] an unavoidable command" rather than "offering the States a legitimate choice." *Id.* at 185.

That is why this Court held in *South Dakota v. Dole*, 483 U.S. 203, 211 (1987), that an exercise of the spending power would violate the Constitution if it were "so coercive as to pass the point at which 'pressure turns into compulsion.'" 483 U.S. at 211. (quoting *Steward Machine Co. v. Davis,* 301 U.S. 548 (1937).

Consequently, the Constitutional test under the Coercion Doctrine is whether, as a practical matter, the programs the Congress adopts leave the states with a true choice regarding their own policies, or whether the states are effectively coerced into following federal commands. Given the enormous taxes and spending of the modern welfare state, this Coercion Doctrine is now essential to maintaining state sovereignty and the Constitutional framework of federalism.

This Doctrine is particularly relevant to conditions on federal aid, as the ACA imposes on Medicaid. Do the conditions as a practical matter leave the states with a true choice regarding whether to accept the aid, or not? In other words, has Congress made an offer the states could not refuse? That is the question that must be decided by this case.

The undisputed facts of this case plainly show that as a practical matter the states no longer retain the true choice of whether to comply with the mandatory requirements that the ACA imposes on Medicaid. Medicaid accounts for 40% of all federal funds granted to the states, and 7% of *all* federal spending, amounting to $276 billion in fiscal year 2011 alone. This Medicaid spending accounts for 20% of state budgets on average, with 50% to 83% financed by federal assistance.

There is no conceivable way that states retain a practical choice to forego such federal Medicaid financing. Yet, states must comply with the entire transformation that the ACA imposes on state Medicaid programs, or lose all of this funding for their current Medicaid programs. Congress, in fact, carefully designed the ACA fully expecting that states retain no realistic choice of opting out of Medicaid.

Consequently, the ACA's Medicaid expansion unconstitutionally violates the Coercion Doctrine, transgressing state sovereignty and the Constitutional framework of federalism.

ARGUMENT

I. IN THE MODERN WELFARE STATE, THE COERCION DOCTRINE IS ESSENTIAL TO MAINTAINING STATE SOVEREIGNTY WITHIN THE CONSTITUTIONAL FRAMEWORK OF FEDERALISM.

Under the Constitution's framework of federalism, the states are not mere subdepartments of the federal government. The states are sovereign entities with their own Constitutionally protected powers which the federal government cannot transgress. Consequently, the federal government does not hold the constitutional power simply to order the states to implement federal policies.

Just last year, this Court reiterated in *Bond v. United States,* 131 S. Ct. 2355, 2366 (2011) that, "Impermissible interference with state sovereignty is not within the enumerated powers of the National Government." The Court added, "our federal system preserves the integrity, dignity, and residual sovereignty of the States." *Id.* at 2364. That is because, "the preservation of the States, and the maintenance of their governments, are as much within the design and core of the Constitution as the preservation of the Union and the maintenance of the National Government." *Texas v. White,* 74 U.S. 700, 725 (1868).

In *New York*, this Court recognized, "No matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the states to regulate" to carry out federal policies. Similarly, this Court recognized in *Printz v. United States,* 521 U.S. 898, 925 (1997) that "the Federal government may not compel the states to implement, by legislation or executive action, federal regulatory programs." The Court added, "It is an essential attribute of the States' retained sovereignty that they remain independent and autonomous within their proper sphere of authority." Id. at 928.

The Founders adopted the policy of federalism and sovereignty of the states in the Constitution as an essential check and balance on the power of the federal government, to preserve liberty. As this Court recognized in *Bond*, the states must "remain independent and autonomous within their proper sphere of authority," because such "federalism secures the freedom of the individual." 131 S. Ct. at 2364. Similarly, this Court in *Gregory v. Ashcroft,* 501 U.S. 452, 459 (1991) recognized, "In the tension between federal and state power lies the promise of liberty."

As Justice Kennedy summarized concurring in *United States v. Lopez,* 514 U.S. 549 (1995),

> "the federal balance is too essential a part of our constitutional structure and plays too vital a role in securing freedom for [the Court] to admit inability to intervene when one or the other level of government has tipped the scales too far."

Justice O'Connor similarly recognized in *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 581 (1985)(dissenting),

> "If federalism so conceived and so carefully cultivated by the Framers of our Constitution is to remain meaningful, this Court cannot abdicate its constitutional responsibility to oversee the Federal government's compliance with its duty to respect the legitimate interests of the States."

This policy, indeed, is embodied in the Tenth Amendment: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people."

Moreover, this Court has long recognized under the Coercion Doctrine that just as Congress has no enumerated power to order states to implement federal policies, it may not use its Spending Power to achieve the same result indirectly. This Court said in *New York*, "Our cases have identified a variety of methods, *short of outright coercion*, by which Congress may urge a state to adopt a legislative program consistent with federal interests." 505 U.S. at 166. The touchstone of "permissible method[s] of encouraging a State to conform to federal policy choices" is that "the residents of the State retain the ultimate decision as to whether or not the State will comply." *Id.* at 168. This Court added in *New York* that Congress violates state sovereignty and the Constitutional framework of federalism when it "issu[es] an unavoidable command" rather than "offering the States a legitimate choice." 505 U.S. at 185.

This Court has analogized the principle to Contract Law. The Court said in *Pennhurst State Sch. & Hosp. v. Holderman*, 451 U.S. 1, 17 (1981), "legislation enacted pursuant to the spending power is much in the nature of a contract." The Court elaborated in *Barnes v. Goldman*, 536 U.S. 181, 186, (2002) "Just as a valid contract requires offer and acceptance of its terms, '[t]he legitimacy of Congress' power to legislate under the spending power...rests on whether the [recipient] *voluntarily* and knowingly accepts the terms of the 'contract.'" *See also Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy,* 548 U.S. 291 (2006). As this Court further explained in *Dole*, to be valid such acceptance must be voluntary "not merely in theory but in fact."

That is why this Court held in *Dole* that an exercise of the spending power would violate the Constitution if it were "so coercive as to pass the point at which 'pressure turns into compulsion.'" 483 U.S. at 211. (quoting *Steward Machine Co. v. Davis,* 301 U.S. 548 (1937). *See also Coll. Sav. Bank v. Fla. Prepaid Postsecondary Educ. Expense Bd.,* 527 U.S. 666 (1999); *Sabri v. United States,* 541 U.S. 600 (2004). The Court similarly recognized in *United States v. Butler*, 297 U.S. 1, 71 (1936), "The power to confer or withhold unlimited benefits is the power to coerce or destroy." The Court similarly noted in *Frost and Frost Trucking Company Co. v. R.R. Comm'n,* 271 U.S. 583, 593 (1926), that without such an effective coercion limit on the spending power, then

> "constitutional guarantees, so carefully safeguarded against direct assault, [would be] open to destruction by the indirect, but no less effective, process of requiring a surrender, which, though in form voluntary, in fact lacks none of the elements of compulsion."

Justice Kennedy recognized as well in *Davis v. Monroe Cnty. Bd. of Educ.,* 526 U.S. 629, 654-55 (1999)(dissenting), that without such a limit, the spending power "has the potential to obliterate distinctions between national and local spheres of interest and power by permitting the Federal government to set policy in the most sensitive areas of traditional state concern, areas which would otherwise be outside its reach."

Consequently, the Constitutional test under the Coercion Doctrine is whether, as a practical matter, the programs the Congress adopts leave the states with a true choice regarding their own policies, or whether the states are effectively coerced into following federal commands. Given the enormous taxes and spending of the modern welfare state, this Coercion Doctrine is now essential to maintaining state sovereignty and the Constitutional framework of federalism.

This Coercion Doctrine is particularly relevant to conditions on federal aid, as the ACA imposes on Medicaid. Do the conditions as a practical matter leave the states with a true choice regarding whether to accept the aid, or not? In other words, has Congress made an offer the states could not refuse?

That is the question that must be decided by this case.

Otherwise, as this Court explained in *Butler*, 297 U.S. at 75 (1936),

> "If, in lieu of compulsory regulation of subjects within the states' reserved jurisdiction, which is prohibited, the Congress could invoke the taxing and spending power as a means to accomplish the same end, clause 1 of section 8 of article 1 would become the instrument for total subversion of the governmental powers reserved to the states."

II. THE ACA'S MANDATORY TRANSFORMATION OF MEDICAID UNCONSTITUTIONALLY VIOLATES THE COERCION DOCTRINE.

The undisputed facts of this case plainly show that as a practical matter the states no longer retain the true choice of whether to comply with the mandatory requirements that the ACA imposes on Medicaid. As discussed above, Medicaid accounts for 40% of all federal funds granted to the states, and 7% of *all* federal spending, amounting to $276 billion in fiscal year 2011 alone.[9] This Medicaid spending accounts for 20% of state budgets on average, with 50% to 83% financed by federal assistance.[10]

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[9] Henry J. Kaiser Found., *Federal and State Share of Medicaid Spending, FY2009* (2010); The President's Budget for Fiscal Year 2012, Historical Tables, Table 8.5.

[10] Nat. Ass'n of State Budget Officers, *2008 State Expenditure Report* (Fall 2009), Table 5.

There is no conceivable way that states retain a practical choice to forego such federal Medicaid financing. Yet, states must comply with the entire transformation that the ACA imposes on state Medicaid programs, or lose all of this funding for their current Medicaid programs.

The ACA Medicaid requirements are even more coercive because the ACA imposes the individual mandate on the poor and needy, but provides no means for them to comply with it other than Medicaid. Consequently, unless the states kowtow to the ACA's federal dictates on Medicaid, they must either untenably bear the entire financial burden of helping the poor comply with the law, or untenably leave them with no means of doing so.

As a practical matter, states do not retain the choice of foregoing federal Medicaid assistance, and raising their own taxes to finance essential Medicaid health care for the poor and needy. For example, in the state of Florida, financing their pre-ACA Medicaid program out of the state's own funds alone would consume two-thirds of the state's tax revenues. Mem. Supp. Pltfs.' Motion Summ. J. 33 [R.E. 493].

Moreover, the individual mandate would still apply to the state's poor and needy. Helping them comply with the additional costs of that would raise the state's financing burden still further. This would be further exacerbated because 18% of the uninsured are currently eligible for Medicaid but not enrolled.[11] But to comply with the individual mandate, all of these individuals would have to enroll.

The federal government already imposes more than $110 billion per year in federal taxes on Florida residents, more than three times the entire state tax burden of $32 billion. Mem. Supp. Pltfs.' Motion Summ. J. 33 [R.E. 493]; Kaiser Found., *Medicaid Spending, FY2009;* Fed'n of Tax Adm'rs, *2009 State Tax Revenue*. That leaves little or no capacity for the state to raise its taxes further to pick up the Medicaid burden without federal funds. To attempt that, all of those federal tax payments from Florida taxpayers would go to finance Medicaid health benefits for the poor and needy of other states, with none coming back for the poor and needy of their own state. That is not a tenable choice for the state. See *Jim C. v. United States,* 235 F.3d 1079, 1083 (8th Cir. 2000)(If a state were to refuse to comply with the conditions on federal funding, "federal taxpayers in [that state] would be deprived of the benefits of a return from the federal government to the state of a significant amount of the federal tax monies collected [from that state].")(Bowman, J. dissenting).

Yet, the ACA deliberately and punitively adds to the coercion by making federal funding for the TANF program contingent on continued state participation in Medicaid as well. ACA, Section 602(a)(3).

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[11] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* 12 (Dec. 2008).

Historically, for prior expansions of Medicaid, Congress avoided this coercion problem by providing new funding for the expansion contingent on states agreeing to the expansion. But Congress did not threaten to take away the pre-existing funding for Medicaid unless states agreed to the expansion.

Congress expressly designed the ACA, however, knowing that states had no realistic alternative except to kowtow to the Congressional Medicaid policies adopted in the Act, precisely because Congress did threaten to take away all pre-existing funding for the entire program unless the states did so. That is why it applied the individual mandate to the poor and neediest with no provision to finance it for them except Medicaid. It knew that the states as a practical matter faced no realistic option to withdraw from Medicaid.

That is also why Congress adopted a new health benefits program to help families purchase the mandated insurance coverage with incomes up to $88,000 a year to start, climbing to over $100,000 a year in short order, but expressly excluded the poor from such subsidies. It knew that the poor would be covered by Medicaid in every state, because the states again as a practical matter retained no realistic option to withdraw from Medicaid.

Indeed, where Congress knew that the poor might not be covered by Medicaid, it expressly provided for eligibility for the new health benefits program. ACA Section 1401(a) carefully provides for such benefits for those who are "not eligible for the Medicaid program…by reason of [their] alien status." But note that no analogous eligibility was provided for the poor in states that might opt out of Medicaid, which again shows Congress itself recognizing that the states retained no realistic ability to opt out. Indeed, Congress no longer even maintains any legal mechanism or procedure by which a state may opt out of Medicaid.

Note also that when Congress knew that the states did retain a realistic ability to opt out of a provsion of the ACA, it provided a fallback provision in that case. The Act specifically provides that when a state chooses to forego the federal funding for setting up a health insurance Exchange for the state, and refuses to do so, the federal government is authorized to set up the Exchange for the state. But the ACA includes no alternative provision for states that might opt out of Medicaid and its federal funding, again recognizing that as a practical matter states retain no realistic option for doing so.

Consequently, for all of the foregoing reasons, this is not a close case. If the ACA does not violate the Coercion Doctrine of *Dole* and *Steward Machine*, no Act of Congress ever will. For the ACA in this case, for the reasons discussed above, "the point of coercion is automatically passed." *Florida Prepaid*, 527 U.S. at 687.

The facts of *Dole* and *Steward Machine* further demonstrate that conclusion. *Steward Machine* involved a federal tax deduction of up to 90% for a federal unemployment tax if a state adopted its own tax to fund an unemployment compensation program satisfying federal requirements. That case was brought by a private employer alleging that the state had been coerced into adopting its tax. But the state opposed the employer's suit, contending that the deduction allowed it a realistic choice of setting up its own program. That was the decisive factor in the court finding no coercion of the state in that case. In sharp contrast, in the present suit, half the states have joined to argue that the ACA does coerce them into acceding to federally imposed policies, with no realistic alternative.

Dole considered the federal provision conditioning 5% of federal highway funding on states establishing a minimum drinking age of 21. The Court found that a "relatively mild encouragement" that was not coercive. 483 U.S. at 211. That contrasts sharply with the federal threat in the present case to withhold all federal Medicaid funding entirely, nearly half of all federal funding for states, more than 1000 times in many states what was at issue in *Dole*. That is more than sufficient to pass the "point at which pressure turns into compulsion," *Steward Machine*, 301 U.S. at 591.

This case is much more like the federal provision found unconstitutional in *New York*, which ordered states to regulate radioactive waste as dictated by Congress, or assume full liability for waste generated within their borders. Similarly, in the present case, the federal government orders states either to run their Medicaid programs as dictated by Congress, or assume full responsibility for medical assistance to the needy within their borders. Consequently, as in *New York*, "Congress has crossed the line distinguishing encouragement from coercion." 505 U.S. at 175.

CONCLUSION

For all of the foregoing reasons, this Court should reverse the summary judgment for Respondents on the Medicaid coercion issue, and hold the ACA's Medicaid expansion unconstitutional, finding the ACA invalid in its entirety as a result.

Respectfully submitted,

PETER FERRARA
Counsel of Record
AMERICAN CIVIL
RIGHTS UNION
310 Cattell Street
Easton, PA 18042
(610) 438-5721
peterferrara@msn.com

SOCIAL SECURITY INSTITUTE
4305 Fauquier Ave.
Suite A
PO Box 216
The Plains, VA 20198
(703) 582-8466

Counsel for Amici Curiae American Civil Rights Union and Social Security Institute

AMICUS
CURIAE
BRIEF

No. 11-400

IN THE

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v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF RESPONDENTS WITH RESPECT TO MEDICAID

SHEREE R. KANNER
CATHERINE E. STETSON*
DOMINIC F. PERELLA
MICHAEL D. KASS
LINDSAY D. BREEDLOVE
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5491
cate.stetson@hoganlovells.com

Counsel for Amici Curiae
**Counsel of Record*

(additional amicus representatives listed on inside cover)

Additional amicus representatives:

MELINDA REID HATTON
MAUREEN D. MUDRON
American Hospital
Association
325 Seventh Street, N.W.
Suite 700
Washington, D.C. 20001
(202) 638-1100

IVY BAER
FRANK R. TRINITY
Association of American
Medical Colleges
2450 N Street, N.W.
Washington, D.C. 20037
(202) 828-0499

JEFFREY G. MICKLOS
Federation of American
Hospitals
750 Ninth Street, NW
Suite 600
Washington, D.C. 20001
(202) 624-1521

BARBARA EYMAN
National Association of Public
Hospitals and Health Systems
1301 Pennsylvania Ave., N.W.
Suite 950
Washington, D.C. 20004
(202) 585-0100

LISA GILDEN
The Catholic Health
Association of the United
States
1875 Eye Street, N.W.
Suite 1000
Washington, D.C. 20006
(202) 296-3993

National Association of
Children's Hospitals
401 Wythe Street
Alexandria, VA 22314
(703) 684-1355

Additional counsel:

SEAN MAROTTA*
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004

**Admitted in New Jersey and New York; Washington, D.C. admission pending*

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BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF RESPONDENTS WITH RESPECT TO MEDICAID

STATEMENT OF INTEREST[1]

The American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals, and National Association of Public Hospitals and Health Systems respectfully submit this brief as *amici curiae*.

The American Hospital Association represents nearly 5,000 hospitals, health care systems, and networks, plus 37,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to, and affordable for, all Americans. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

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[1] No party or counsel for a party authored or paid for this brief in whole or in part, or made a monetary contribution to fund the brief's preparation or submission. No one other than *amici* or their members or counsel made a monetary contribution to the brief. All parties filed blanket *amicus* consent letters.

The Association of American Medical Colleges represents about 300 major non-federal teaching hospitals, all 136 accredited medical schools, and the clinical faculty and medical residents who provide care to patients there. AAMC member hospitals provide some 28 percent of the nation's Medicaid inpatient care. AAMC, *Cuts to Doctor Training Will Hurt the Nation's Health, Economy* (Sept. 19, 2011).[2]

The Catholic Health Association of the United States is the national leadership organization for the Catholic health ministry. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

The Federation of American Hospitals is the representative of investor-owned or managed community hospitals and health systems. FAH has nearly 1,000 member hospitals in 46 states and Washington D.C. These members include rural and urban teaching and non-teaching hospitals and provide a wide range of acute, post-acute, and ambulatory services.

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[2] *Available at* https://www.aamc.org/download/262676/data/gmefactsheet.pdf.

The National Association of Children's Hospitals supports its 221 hospital members in addressing public policy issues. N.A.C.H.'s mission is to promote the health and well-being of children and their families through support of children's hospitals and health systems. Medicaid is the single largest insurer of children and the largest payer for children's hospitals. On average, Medicaid covers around 50 percent of the care provided by children's hospitals.

The National Association of Public Hospitals and Health Systems is comprised of some 140 of the nation's largest metropolitan safety net hospitals and health systems, committed to providing health care to all without regard to ability to pay. The majority of patients served by NAPH members are either uninsured or enrolled in Medicaid, accounting for 54 percent of all inpatient discharges and 57 percent of all outpatient visits. NAPH represents members' interests in matters before Congress, the Executive Branch, and the courts.

The six Hospital Associations represent virtually every hospital and health system in the country. They regularly participate as *amici* in cases raising issues of concern to the healthcare field, including other cases currently before this Court arising out of the Patient Protection and Affordable Care Act ("ACA"). They are participating here because healthcare providers are at the heart of federal-state cooperative health care payment programs such as Medicaid. Petitioners' "coercion" theory would threaten those programs, handcuffing Congress in its attempts to innovate and to ensure that Medicaid operates effectively for healthcare providers and their patients. That outcome is neither wise nor compelled by the Constitution.

SUMMARY OF ARGUMENT

Petitioners argue that if a state cannot "afford to turn down" the "federal inducement" of Medicaid funding, then the Medicaid program amounts to unlawful "coercion" and the ACA's Medicaid provisions must fall. Pet. 23. It is important to understand the practical consequences of that argument for America's healthcare providers and the patients they serve. Congress has seen fit to modify Medicaid dozens of times over the decades to expand eligibility and expand or contract states' flexibility regarding coverage and provider compensation. *See infra* at 18-19. Congress enacted these and many similar modifications because it became convinced that they were necessary to keep the system running smoothly in light of changes on the ground. But if Petitioners' "coercion" theory were law, Congress could not make *any* modifications to the Medicaid program—or to any other significant cooperative federal-state program—unless *every participating state agreed to the proposed change*.

This heckler's veto flips the Constitution on its head. *See M'Culloch* v. *Maryland*, 17 U.S. 316, 330 (1819) (rejecting suggestion "that congress can only exercise its constitutional powers, subject to the controlling discretion, and under the sufferance, of the state governments"). And it has the potential to wreak havoc on hospitals and their patients. If Congress determines that hospitals are being under-compensated for treating a category of Medicaid patients, or that certain recipients need additional services, it must have the prerogative to revise the program accordingly. Patients have nowhere else to turn for treatment, and providers have nowhere else to turn for payment.

These practical concerns underscore the legal flaws that doom Petitioners' case. Their coercion arguments should be rejected, and the ACA's Medicaid provisions sustained, for three primary reasons:

1. The "coercion doctrine," always more a whisper than a doctrine, is unworkable. It also has been overtaken by events: The anti-commandeering principle, developed by this Court in the years since it last mentioned "coercion," does the necessary work to safeguard federalism. The Court should abandon any separate coercion inquiry, recognizing, as it has in other contexts, that there is a distinction of constitutional magnitude between encouragement—no matter how persuasive—and direct legislative command.

2. If the Court were to decide there is a coercion doctrine, it should limit the doctrine's application to cases where Congress attempts to regulate activities outside "the scope of national policy and power." *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 590 (1937). After all, this Court was motivated to suggest a coercion theory in the first place by the concern that Congress might use the Spending Power to usurp the states' police powers, eliminating the line between federal and state authority. That concern has no resonance in cases, like this one, where Congress regulates within a longtime federal sphere. In such cases, the only concern should be to ensure that Congress is not commandeering the states "by directly compelling them to enact and enforce a federal regulatory program." *New York* v. *United*

States, 505 U.S. 144, 161 (1992) (citation omitted). The ACA's Medicaid provisions do not constitute commandeering. They should be sustained.

3. Finally, even if the Court decided to recognize a coercion doctrine, and even if it applied in this case, the Court still should affirm the holding below. The ACA's Medicaid provisions are not impermissibly coercive. States remain free to decline the federal government's Medicaid payments. And while Petitioners assert the contrary, that assertion is belied by the fact that legislators from some of the Petitioner states have recently, and publicly, considered dropping out of the Medicaid program. *See, e.g.*, D. Montgomery, *Push to Opt Out of Medicaid Alarms Texas Health Providers*, Fort Worth Star-Telegram (Nov. 14, 2010).[3] The Petitioner states may face difficult *political* decisions about whether and how to participate in Medicaid, but they cannot show actual "coercion." The decision below regarding Medicaid should be affirmed.

ARGUMENT

I. THIS COURT SHOULD REJECT PETITIONERS' COERCION THEORY.

A. The Coercion Theory Is Both Unworkable And Unnecessary.

1. The Court has said very little about the "coercion doctrine"; indeed, it has only suggested—and it never has held—that the doctrine exists at all. *See Steward Mach.*, 301 U.S. at 590 ("Nothing in the case suggests the exertion of a power akin to undue influence, if we *assume* that such a concept can ever

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[3] *Available at* http://www.mcclatchydc.com/2010/11/14/103709/texas-push-to-opt-out-of-medicaid.html.

be applied with fitness to the relations between state and nation.") (emphasis added); *South Dakota* v. *Dole*, 483 U.S. 203, 211 (1987) ("Our decisions have recognized that in some circumstances the financial inducement offered by Congress *might* be so coercive as to pass the point at which 'pressure turns into compulsion.' ") (citation omitted; emphasis added).

It should now abandon the theory altogether. The notion that judges can determine in some principled way the point at which "pressure" applied to a state "turns into compulsion," *Dole*, 483 U.S. at 211, was doomed from the start. How can a judge possibly decide, as an empirical matter, whether a state is truly "coerced" in the sense that it has no choice but to accept federal funds? How large must the federal program be, and what percentage of the state's budget must it provide? And even if a judge could determine that a particular state is "coerced," how many states must fall into that category before the congressional program is invalidated? What if 49 states could refuse the federal funds without difficulty but one, faced with idiosyncratic budget pressures, could not? There is no way to draw principled lines. These are not the sorts of metrics that make for a coherent constitutional rule.

The Courts of Appeals have recognized as much. The D.C. Circuit, for example, questioned its competency to determine "whether the states are faced * * * with an offer they cannot refuse or merely a hard choice." *Oklahoma* v. *Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981). And the Ninth Circuit recognized the "[t]he difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities." *Nevada* v. *Skinner*, 884 F.2d 445, 448 (9th Cir. 1989). Just so. To ask whether "there is any form or level of inducement that can truly render someone unable to choose"—not to mention "what choice and compulsion mean when we are talking about *states* rather than persons"—is to delve into a "deep[ ] philosophical question." L. Tribe, *American Constitutional Law* 841 (3d ed. 2000). Federal courts are not well-suited to adjudicate philosophical questions. Indeed, the impossibility of the task is underscored by this very case: Petitioners insist that the ACA's expansion of Medicaid is the most extreme example of coercion that will ever arise, Pet. 21, and yet even on these supposedly extreme facts the states are not truly "coerced." *See infra* at 15-23.[4]

2. Moreover, the notion that underlies the coercion theory—that governmental encouragement has the same constitutional effect as a direct command if only the facts are sufficiently extreme—contradicts this Court's teachings in other areas. In contexts as diverse as criminal law and the First Amendment, the Court has recognized that encouragement, no matter how forceful, is *not* the same as a command. *See, e.g., Christian Legal Soc'y* v. *Martinez*, 130 S. Ct. 2971, 2986 (2010) ("[O]ur decisions have distin-

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[4] Notably, the states themselves historically have failed to agree about whether the "coercion" theory is workable. In *Dole*, the National Conference of State Legislatures and the National Governors' Association, among others, filed an amicus brief warning of "the difficulties inherent in determining 'the location of the point at which pressure turns into compulsion' " and arguing against adoption of a "coercion" test. Amicus Br. of the Nat'l Conference of State Legislatures et al., 1987 WL 880310, at *16-*17 (Jan. 22, 1987) (citation omitted). And many states and state officials disagree with the Petitioners in the current case and have argued in favor of affirmance on the Medicaid issue. *See infra* at 17.

guished between policies that require action and those that withhold benefits") (collecting cases).[5] To conflate the two—to try and identify that point where "encouragement" becomes an *implicit* "command"—is to venture too far into the philosophical thicket. Every offer of money "is in some measure a temptation," but "to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." *Steward Mach.*, 301 U.S. at 589-590.

3. Rejecting the coercion theory would not leave states unprotected. That is so because the "anti-commandeering" principle this Court established in *New York* v. *United States* ensures that the federal government cannot directly command the states to implement regulatory programs. That principle protects the states against federal encroachment. It properly distinguishes encouragement from compulsion. And its bright-line test avoids the insoluble problems of the coercion theory. This Court should hold that the anti-commandeering doctrine has supplanted any attempt to identify "coercion" in Congress' interactions with the states.

In *New York*, the Court held that Congress cannot " 'commandeer' state governments into the service of federal regulatory purposes." 505 U.S. at 175. That is to say, Congress cannot directly command the states to regulate in a certain way. Petitioners argue that the ACA's Medicaid provisions effectively amount to commandeering because they are so coercive as to take away the states' choice. *See* Pet. Br. 25. But that argument distorts the holding of *New York*. The *New York* Court explained that state sovereignty is offended by direct commands from the federal government because the state's citizens no longer "retain the ultimate decision as to whether or not the State will comply." 505 U.S. at 168. Yet where Congress "*encourages* state regulation rather than compelling it, state governments remain responsible to the local electorate's preferences[.]" *Id.* (emphasis added). That distinction is in line with *Martinez*. Moreover, *New York* never mentioned coercion—in the sense of an offer being too good to refuse—as a free-standing check on the Spending power. Instead, it referred to "four respects" in which a congressional grant might contravene the Spending Clause, none of which was coercion. *Id.* at 171-172.

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[5] This distinction lends no support to arguments against the ACA's minimum-coverage provision. Petitioners' objection to the minimum-coverage provision is that it impermissibly bootstraps the Commerce power by compelling purportedly "inactive" individuals to enter commerce. That is a constitutionally distinct argument. And it fails for the reasons stated by the federal government in the minimum-coverage proceeding.

In the wake of *New York*, commentators suggested that the "anti-commandeering" test had supplanted *Dole*'s "coercion" theory: So long as the federal government does not command states to carry out federal policies, the states are not constitutionally coerced. *See* K. Sayers-Fay, *Conditional Federal Spending: A Back Door to Enhanced Free Exercise Protection*, 88 Cal. L. Rev. 1281, 1299-1300 (2000); C.R. McConville, *Federal Funding Conditions: Bursting Through the* Dole *Loopholes*, 4 Chap. L. Rev. 163, 175-177 (2001). This Court should embrace that reading of *New York*. It aligns the Spending Clause jurisprudence with other areas of the law. It requires no deep dive into states' financial ledgers. And it avoids the "endless difficulties," *Steward*

Mach., 301 U.S. at 590, of drawing the elusive line between encouragement and compulsion.

Applying this sensible reading, the Court should affirm the decision below. The anti-commandeering rule prohibits only direct federal commands compelling state action. *See New York*, 505 U.S. at 161 (Congress may not " 'commandee[r] the legislative process of the States by *directly compelling* them to enact and enforce a federal regulatory program.' ") (quoting *Hodel* v. *Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 288 (1981)) (emphasis added); *Printz* v. *United States*, 521 U.S. 898, 933 (1997). The ACA's Medicaid provisions do not meet that description. Encouragement, however forceful, is just that. The Medicaid statute encourages—some may say strongly encourages—state participation. But it does not commandeer the states. The Eleventh Circuit's ruling on the Medicaid issue should be affirmed.

B. If The Coercion Theory Is Viable, It Should Be Limited To Cases Where Congress Tries To Invade The States' Police Power.

1. Even if the coercion theory were viable, it should be limited in application to the category of cases that gave rise to it in the first place—those in which Congress attempts to intrude on the States' police power.

On the rare occasions when the Court has mentioned the coercion theory, it has always framed its concern as one about congressional attempts to usurp the reserved authority of the States. In *United States* v. *Butler*, 297 U.S. 1 (1936), for example, the Court wrote that the Framers' writings "will be searched in vain for any suggestion" that the Spending Clause contains "authority whereby * * * the independence of the individual states [may be] obliterated, and the United States converted into a central government exercising uncontrolled police power in every state of the Union, superseding all local control or regulation of the affairs or concerns of the states." *Id.* at 77. And in *Steward Machine*, the Court expressed concern about Congress attempting to "intrude upon fields foreign to its function." 301 U.S. at 590; *see also United States* v. *Comstock*, 130 S. Ct. 1949, 1964 (2010) (expressing desire to avoid "confer[ring] on Congress a general police power, which the Founders denied the National Government and reposed in the States") (citation omitted).

If the coercion theory has any resonance at all, it is in cases presenting this concern. One could imagine a situation where Congress attempted to intrude on the States' traditional local police powers by, for example, threatening to withhold all federal funding unless the States agree to change their zoning laws, or to eliminate no-fault divorce. While the States would retain the political capacity to reject Congress' pressure, *see supra* at 7-8, more searching judicial oversight nonetheless might be appropriate to safeguard the States' prerogative to "remain independent and autonomous within their proper sphere of authority." *Printz*, 521 U.S. at 928.

But that concern has no application where Congress is regulating "activities fairly within the scope of national policy and power." *Steward Mach.*, 301 U.S. at 590. In such circumstances, Congress by definition does not "intrude upon fields foreign to its function," *id.*, or "exercis[e] uncontrolled police power," *Butler*, 297 U.S. at 77. Federalism is not at risk. There accordingly is no reason in such cases to involve the courts in the tricky exercise of discerning "the point at which pressure turns into compulsion." *Dole*, 483 U.S. at 211. Instead, the courts should employ the bright-line check provided by the anti-commandeering doctrine. *See supra* at 9-11.

2. To be sure, the Court has never articulated this limit on the coercion theory. But the limit is suggested by a comparison between *Dole* and *New York*. In *Dole*, the Court was faced with a congressional attempt to intrude on an area—control over the drinking age—that falls within the state's traditional police power. *See* 483 U.S. at 206, 211-212. Because Congress' attempt to pressure South Dakota to adopt a 21-year-old drinking age risked intruding on the state's traditional prerogatives, the Court raised the issue of coercion; it considered (but did not decide) whether the incentive offered was so coercive as to be impermissible. *See id.* at 211.

In *New York*, by contrast, the regulatory issue—treatment and disposal of low-level radioactive waste—was indisputably a matter of federal concern; as the Court explained, "Congress has substantial power under the Constitution to encourage the States to provide for the disposal of the radioactive waste generated within their borders." 505 U.S. at 149. There accordingly was no concern that congressional Spending Clause regulation would interfere with traditional state prerogatives. And in that setting, the Court said nothing about coercion. It focused instead on the risk that Congress would directly commandeer state legislative processes, rendering state officials unaccountable to their constituents. *See id.* at 169.

3. Deciding whether Congress is using its Spending Clause prerogatives to encourage "activities fairly within the scope of national policy and power," *Steward Mach.*, 301 U.S. at 590, would, of course, require judicial line-drawing. But the inquiry would not be unprecedented. The Court has recognized in other settings that the federal government's historical role in a field is relevant to determining the balance of power between national and state governments. In the preemption context, for example, the Court has suggested that the presumption against preemption is inapplicable "when the State regulates in an area where there has been a significant history of federal presence." *United States* v. *Locke*, 529 U.S. 89, 108 (2000). If that inquiry is administrable in the preemption context, it is administrable here too.

4. Applying these principles—and, again, assuming the coercion theory is recognized at all—the Court should eschew the theory here. Medicaid provides payment for health care services through a long-existing federal program that, in many ways, serves as a public analogue of health insurance. Moreover, federal involvement in providing and regulating health care and insurance long predates Medicaid. More than 200 years ago, Congress enacted an "Act for the relief of sick and disabled seamen" that was the genesis for the National Public Health Service. J. Parascandola, Public Health Service Commissioned Officers Foundation, *History*.[6] This Court later described the problem of caring for the unemployed and elderly—a problem comparable to the one addressed by Medicaid—as "plainly national in area

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[6] *Available at* http://www.coausphs.org/docs/history.pdf.

and dimensions." *Helvering* v. *Davis*, 301 U.S. 619, 643-644 (1937). Congress likewise has long had a presence in the health care field by virtue of the Medicare program. And it is settled that insurance is a matter of federal concern: While Congress made the affirmative decision to leave much insurance regulation in the states' hands, *see* 11 U.S.C. § 1012 (McCarran-Ferguson Act), it has Commerce Clause authority to regulate insurance and has done so in many instances, including through the ACA itself. *See United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533, 551-553 (1944) (insurance regulation is within the Commerce power).

The ACA's Medicaid provisions, in short, address "activities fairly within the scope of national policy and power," not "fields foreign to [Congress'] function." *Steward Mach.*, 301 U.S. at 590. The only question for the Court accordingly should be whether the provisions commandeer the States. They do not, for the reasons already discussed. The decision below should be affirmed against petitioners' Medicaid challenge.

II. EVEN IF THE COERCION THEORY APPLIED HERE, IT WOULD NOT INVALIDATE THE ACA'S MEDICAID PROVISIONS.

Finally, even if the coercion theory were recognized, and even if it applied in these circumstances, the ACA's Medicaid provisions would survive review. Petitioners argue that they cannot extricate themselves from Medicaid. That assertion does not withstand scrutiny—not least because some of these very Petitioners have announced they are considering the very step they claim is impossible.

To be sure, exiting Medicaid would be politically difficult, and it could be expensive. But that mere hard choice cannot amount to unconstitutional coercion. If it did, the states could freeze a federal program, and block Congress from improving it in any significant way, so long as *one* participating state decides to wave a red flag. Medicaid recipients and health care providers—the two constituencies that interact with and rely on Medicaid the most—would be unable to count on Congress to make the adjustments needed to keep the program working effectively. That is not a sensible rule of law.

1. Petitioners suggest throughout their brief that it is impossible for them to withdraw from Medicaid, and that accordingly the situation here amounts to commandeering by another name. *E.g.*, Pet. Br. 26. But they cannot quite bring themselves to say it outright. Instead, they hedge: They assert that a state's "*practical ability* to ask residents" to exit Medicaid and pay for a state health insurance program "*is all but nil*," Pet. Br. 43 (emphases added), and they claim that "Florida has no *practical ability to inform its citizens*" that it will be declining federal monies and raising state taxes to offset the loss. Pet. Br. 44 (emphasis added).

There is a reason for this cautious phrasing: Any claim that it is impossible to exit Medicaid would not withstand scrutiny. For starters, the words of Petitioners' own state legislators would cast doubt on the assertion. Lawmakers in Texas—one of the Petitioner states—recently pondered the very move that Petitioners now suggest is impossible: dropping out of the Medicaid program. *See* Montgomery, *supra*. "The opt-out plan * * * quickly emerged as another high-profile topic for the 2011 Legislature," championed by "a number of conservative lawmakers who believe that Texas can provide health coverage to the indigent more efficiently with a state-run plan free of federal mandates." *Id.* And as recently as last winter—at a time when this litigation was already in full swing—a legislator in Florida threatened that state's withdrawal from Medicaid, stating that "[i]f the federal government elects not to allow us to manage the program the way we believe is in Florida's best interests, then we'll operate our Medicaid program with our resources." B. Larrabee, *Florida Might Try to Withdraw From Medicaid*, Florida Times-Union, Feb. 16, 2011.[7]

Those statements undercut the Petitioners' primary factual contention. And they are hardly outliers. As the Solicitor General points out, many states and state legislators have filed briefs in support of the PPACA's Medicaid amendments in this case, telling the Court both that the amendments are good for states and that states could withdraw from the Medicaid program if necessary. *See* Govt' Br. 34-35. Indeed, in the proceeding below, legislators from 26 states—*including 15 of the Petitioner states*—disputed the Petitioners' coercion claims and acknowledged that "States could opt out of [Medicaid] if their leaders and citizens so desired, avoiding the Act's new requirements for expanded Medicaid coverage." Amicus Br. of State Legislators, 2011 WL 1461595, at *1, *27 (Apr. 7, 2011).

Nor would Texas and Florida be the first states to make do without Medicaid. Arizona, another of the Petitioners in this proceeding, did not offer any sort of Medicaid program until 1982—17 years after the program began—and even today it is not a full participant in the usual sense. The state now offers "an alternative to traditional Medicaid," called the Arizona Health Care Cost Containment System, as a demonstration project approved by the federal government. N. McCall, *Lessons from Arizona's Medicaid Managed Care Program*, Health Affairs, July-Aug. 1997, at 194.[8]

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[7] *Available at* http://jacksonville.com/news/florida/2011-02-16/story/florida-might-try-withdraw-medicaid.

These data points show that it is not impossible for a state to remain separate from or exit Medicaid. And indeed, a number of courts have rejected the precise argument Petitioners make here: that "while [a state's] choice to participate in Medicaid may have been voluntary, it now has no choice but to remain in the program in order to prevent a collapse of its medical system." *California* v. *United States*, 104 F.3d 1086, 1092 (9th Cir. 1997); *see also*, *e.g.*, *Schweiker*, 655 F.2d at 414. As the *California* court observed, it is nearly impossible for a court to know whether "a sovereign state[,] which is always free to increase its tax revenues," is actually being "coerced by the withholding of federal funds." 104 F.3d at 1092 (citation omitted). It refused to find coercion on the record of that case. *Id.* Nothing of substance has changed in the intervening years.

2. Petitioners contend that this case *is* different because the ACA "revolutionizes" Medicaid in a way past modifications did not. Pet. Br. 34. That overstates the case. The ACA's Medicaid provisions are part of a long line of measures expanding the scope of the program and the requirements it imposes on

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[8] *Available at* http://content.healthaffairs.org/cgi/reprint/16/4/194.pdf.

participants. For example, 1972 amendments "[r]equired states to extend Medicaid to [Supplemental Security Income] recipients or to elderly and disabled" people meeting certain criteria. Kaiser Comm'n on Medicaid & The Uninsured, *The Medicaid Resource Book* 175 (App'x 1) (2002) ("*Medicaid Resource Book*").[9] A 1984 amendment "[r]equired states to cover children born after September 30, 1983, up to age 5, in families meeting state [welfare] income and resource standards." *Id.* And since 1991, states have been "required to cover all children over the age of five and under 19 who are in families with income below 100% of the federal poverty level." Congressional Res. Serv., *How Medicaid Works: Program Basics* 4 (2005).[10] With respect to the income criteria, amendments enacted between 1986 and 1991 "require [states] to cover pregnant women and children under age 6 with family incomes below 133% of the federal poverty income guidelines." *Id.* at 3-4. And a 1990 amendment "[r]equired states to phase in coverage of Medicare premiums for low-income Medicare beneficiaries with incomes between 100 and 120 percent of poverty." *Medicaid Resource Book* 176.

The current expansions to the Medicaid program are no different in kind from what came before. And states throughout have remained (and continue to remain) free to withdraw from the Medicaid program. As this Court itself has recognized, "participation in the program is voluntary[.]" *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

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[9] *Available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14255.

[10] *Available at* http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3227703162005.pdf.

3. Petitioners separately argue that their citizens' federal tax burden somehow renders the ACA Medicaid provisions coercive. They assert that it would be all but impossible "to ask residents, already taxed by the federal government to provide health insurance elsewhere, to contribute additional taxes to supplant the declined federal program," and they compare the federal government to a "pickpocket who takes a wallet and gives the true owner the 'option' of agreeing to certain conditions to get the wallet back or having it given to a stranger." Pet. Br. 43-44.

This argument is far off the mark. Unlike the victim in Petitioners' colorful analogy, state residents do not actually have any "owner[ship]" rights or expectations in federal tax dollars. *Id.* In 2003-04, for instance, New Jersey received 55 cents in federal spending for every dollar its residents paid in federal taxes. C. Dubay, Tax Foundation, *Federal Tax Burdens and Expenditures by State: Which States Gain Most from Federal Fiscal Operations?* 2 (March 2006).[11] During that same period, Mississippi received $1.77 in federal spending for every federal tax dollar contributed by its residents. *Id.* For better or worse, state residents cannot reasonably expect to receive a perfect quid pro quo for their federal tax dollars. And it is, at best, doubtful whether a state's limited "return" on its residents' federal tax contributions in any way constrains that state's ability to impose new taxes. By way of example, in spite of the fact that historically it has received in federal spending only a fraction of the federal tax dollars contributed by its residents, *id.*, New Jersey boasts one of the highest state and local tax burdens in the nation.

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[11] *Available at* http://www.taxfoundation.org/files/sr139.pdf.

Tax Foundation, *2011 Facts & Figures: How Does Your State Compare?* at Tbl. 2 (2001).[12]

In any event, it is far from clear that withdrawing from Medicaid would require the states to raise taxes. The Heritage Foundation came to just the opposite conclusion in a recent study, finding that "about 40 states would save money overall by opting out of Medicaid, even if they continued to provide some services, and despite the loss of federal support." M. DoBias, *What if States Drop Medicaid?*, Nat'l J. (Nov. 18, 2010).[13] Whatever the validity of that estimate, it apparently spurred some Petitioner states to consider exiting Medicaid in the first place. *See id.* And that fact further undercuts Petitioners' theory of the case: In the real world, at least some of the Petitioners are unsure whether exiting Medicaid would even be a fiscal hardship—much less a fiscal impossibility.

4. The states' argument, in the end, is merely that it would be difficult to defend a Medicaid withdrawal to their citizens. But "[h]ard choices do not alone amount to coercion." *Van Wyhe* v. *Reisch*, 581 F.3d 639, 652 (8th Cir. 2009) (citation omitted). This Court said exactly that in *New York*: "If a State's citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant." 505 U.S. at 168. By contrast, "[i]f state residents would prefer their government to devote its attention and resources to problems other than those deemed important by Congress, they may choose to have the Federal Government rather than the State

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[12] *Available at* http://www.taxfoundation.org/files/ff2011.pdf.

[13] *Available at* http://www.nationaljournal.com/member/magazine/what-if-states-drop-medicaid--20101118.

bear the expense of a federally mandated regulatory program[.]" *Id.*

State legislators are charged with determining the will of their constituents on these matters. If they misjudge, they should be held accountable in the next election. That is the very essence of republican government. Whatever its proper scope (if any), the coercion theory cannot be used to shield legislators from their responsibilities in the system.

5. Finally, as we mentioned at the outset, it is critical to understand the practical consequences of the argument Petitioners advance: If their theory were law, *all* of the important modifications Congress has made to Medicaid over the decades—modifications that were necessary to respond to demographic developments, innovations in the medical delivery system, and other changes on the ground—could have been blocked by a lone participant state. Or, perhaps more likely, states would have blocked the changes that increased their costs and allowed others to stand. *Cf.* Pet. Br. 49 ("[W]hen no State even 'suggest[s]' spending legislation is coercive, * * * that is certainly a strong indication that States' acceptance of federal conditions was voluntary[.]") (citation omitted).

Moreover, under Petitioners' theory, states could wield their heckler's veto to block any adjustment Congress might make to Medicaid in the future—not just significant amendments, but adjustments as routine and minor as new quality measures or reporting requirements. After all, Petitioners contend that it is the size of the grant the state stands to lose, not the activity the federal government asks states to undertake, that provides the measure of coercion.

Pet. Br. 46. If that is so, every Medicaid amendment is just as "coercive" as the ones at issue here. Congress would be able to make even non-substantive changes to the program only at the states' pleasure.

This Court should reject that approach. It is legally unsound. And it also is treacherous for those who rely on cooperative federal-state programs and on Congress' ability to keep those programs running smoothly and fairly. Congress' best judgment on these matters cannot be held hostage at the whim of some objecting states.

CONCLUSION

For all of the foregoing reasons, this Court should uphold the Medicaid provisions of the ACA.

Respectfully submitted,

MELINDA REID HATTON
MAUREEN D. MUDRON
American Hospital
Association
325 Seventh Street, N.W.
Suite 700
Washington, D.C. 20001
(202) 638-1100

IVY BAER
FRANK R. TRINITY
Association of American
Medical Colleges
2450 N Street, N.W.
Washington, D.C. 20037
(202) 828-0499

JEFFREY G. MICKLOS
Federation of American

SHEREE R. KANNER
CATHERINE E. STETSON*
DOMINIC F. PERELLA
MICHAEL D. KASS
LINDSAY D. BREEDLOVE
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5491
cate.stetson@hoganlovells.com

BARBARA EYMAN
National Association of Public
Hospitals and Health Systems
1301 Pennsylvania Ave., N.W.
Suite 950
Washington, D.C. 20004
(202) 585-0100

Hospitals
750 Ninth Street, NW
Suite 600
Washington, D.C. 20001
(202) 624-1521

National Association of
Children's Hospitals
401 Wythe Street
Alexandria, VA 22314
(703) 684-1355

LISA GILDEN
The Catholic Health
Association of the
United States
1875 Eye Street, N.W.
Suite 1000
Washington, D.C. 20006
(202) 296-3993

Counsel for Amici Curiae
**Counsel of record*

Additional counsel:

SEAN MAROTTA*
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004

**Admitted in New Jersey and New York; Washington, D.C. admission pending*

February 17, 2012

AMICUS
CURIAE
BRIEF

Nos. 11-393 & 11-400

IN THE
Supreme Court of the United States

FLORIDA, *et al.*,
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v.
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On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF NEITHER PARTY ON SEVERABILITY

SHEREE R. KANNER
CATHERINE E. STETSON*
DOMINIC F. PERELLA
MICHAEL D. KASS
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5491
cate.stetson@hoganlovells.com

Counsel for Amici Curiae
**Counsel of Record*

(additional amicus representatives listed on inside cover)

Additional amicus representatives:

MELINDA REID HATTON
MAUREEN D. MUDRON
American Hospital Association
325 Seventh Street, N.W.
Suite 700
Washington, D.C. 20001
(202) 638-1100

BARBARA EYMAN, General Counsel
National Association of Public Hospitals and Health Systems
1301 Pennsylvania Ave., N.W.
Suite 950
Washington, D.C. 20004
(202) 585-0100

JEFFREY G. MICKLOS
Federation of American Hospitals
801 Pennsylvania Ave.
Suite 245
Washington, D.C. 20004
(202) 624-1521

IVY BAER
FRANK R. TRINITY
Association of American Medical Colleges
2450 N Street, N.W.
Washington, D.C. 20037
(202) 828-0499

Additional counsel:

SEAN MAROTTA*
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004

**Admitted in New Jersey and New York; Washington, D.C. admission pending*

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BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF NEITHER PARTY ON SEVERABILITY

STATEMENT OF INTEREST[1]

The American Hospital Association, Association of American Medical Colleges, Federation of American Hospitals, and National Association of Public Hospitals and Health Systems respectfully submit this brief as *amici curiae.*

The American Hospital Association represents nearly 5,000 hospitals, health care systems, and networks, plus 37,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to, and affordable for, all Americans. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

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[1] No party or counsel for a party authored or paid for this brief in whole or in part, or made a monetary contribution to fund brief's preparation or submission. No person other than *amici* or their members or counsel made a monetary contribution to the brief. All parties filed blanket *amicus* consent letters.

The Association of American Medical Colleges represents about 300 major non-federal teaching hospitals, all 136 accredited medical schools, and the clinical faculty and medical residents who provide care to patients there.

The Federation of American Hospitals is the representative of investor-owned or managed community hospitals and health systems. FAH has nearly 1,000 member hospitals in 46 states and Washington D.C. These members include rural and urban teaching and non-teaching hospitals and provide a wide range of acute, post-acute, and ambulatory services.

The National Association of Public Hospitals and Health Systems is comprised of some 140 of the nation's largest metropolitan safety net hospitals and health systems, committed to providing health care to all without regard to ability to pay. NAPH represents members' interests in matters before Congress, the Executive Branch, and the courts.

The four Hospital Associations represent the vast majority of the nation's hospitals and health systems. Their members are deeply affected by the nation's health care laws, which is why they have filed *amicus* briefs in many of the Patient Protection and Affordable Care Act ("ACA") cases. They are participating again here for the same reason: This Court's severability decision—to the extent it needs to make one at all—would affect hospitals as directly as will its decision whether to uphold the individual mandate in the first place. The ACA is a sprawling statute with myriad provisions, some tied tightly to the individual mandate and others less so. *Amici* write to offer the Court guidance, from the hospitals' perspective, on ACA provisions that are intimately related to the mandate but that thus far have received scant attention from the parties.

SUMMARY OF ARGUMENT

1. This Court need not reach the severability question at all, because it should affirm the constitutionality of the individual mandate.

2. To the extent the Court reaches severability, it should decide the issue in this proceeding, rather than remand for fact-finding. That is the Court's usual practice, and the Court should adhere to it here. A remand would mean months or years of continued uncertainty for hospitals and others in the health care field as the severability issue makes its slow way back down to, and back up from, the district court. That uncertainty would be deeply damaging. ACA implementation requires extensive effort from health care providers and regulators across the country. Health care providers, and the patients they serve, cannot afford to wait in limbo for several more years before they learn which ACA provisions will stand and which—if any—will fall.

3. While *amici* are concerned about the guaranteed-issue and community-rating questions—both are important reforms—that is an issue on which this Court is receiving ample briefing. *Amici* wish to focus instead on a segment of the ACA that to date has received scant attention: its hospital-related Medicare and Medicaid spending cuts and penalties. The ACA contains several provisions that either slash the reimbursements hospitals receive for treating Medicare and Medicaid patients or require hospitals to engage in extensive additional spending

to meet new ACA mandates. Three of these provisions are intimately bound up with the individual mandate and would not have been enacted without it. If the Court strikes down the mandate, these provisions should fall as well. To leave them in place absent the mandate would impose massive additional burdens on hospitals, depriving them of resources to meet the needs of their patients. Congress did not intend that result.

ARGUMENT

I. THE COURT SHOULD UPHOLD THE INDIVIDUAL MANDATE AND DECLINE TO REACH SEVERABILITY.

The hospital associations urge the Court to uphold the individual mandate, rendering severability moot. As will be discussed in our brief in the individual mandate proceeding, some 50 million Americans lack health insurance, the vast majority seek and receive health care, and the cost of that care amounted to $86 billion in 2008 alone. That comes at a steep cost to everyone, including the uninsured, taxpayers, and hospitals and health care systems. These facts are relevant here both because they demonstrate the mandate's importance—it is absolutely necessary to alleviate the crisis of uninsurance and uncompensated care—and because they doom the petitioners' Commerce Clause arguments. It is perfectly obvious that the uninsured "substantially affect" the interstate markets in health care and health insurance. And even if petitioners' activity/inactivity distinction were coherent, it would fail because the uninsured are "active" in both the health *care* market—because they obtain care—and in the health *insurance* market—because even those who do not seek access to that market in a given year obtain the present benefit of an insurance-funded infrastructure that will care for them when they need it.

II. THE COURT SHOULD DECIDE SEVERABILITY ITSELF RATHER THAN REMAND.

If the Court reaches severability, one thing is certain: It should resolve that issue in this proceeding. To remand for further severability analysis would be ruinous. It would take months or more likely years. And it would leave the field saddled with crippling uncertainty about which ACA provisions—and which of the thousands of regulations spawned from those provisions—will remain good law.

1. If this Court were to remand to the District Court for severability findings, the inevitable result would be extended delay. And it is unlikely either side would be satisfied with the district court's decision. The result: further appeals, with the issue eventually landing back at this Court's doorstep.

For several reasons, that sort of delay would be harmful to American health care.

First, it would be disastrous for hospitals, health care systems, physicians, and the patients they serve. Hospitals face an enormously complex regulatory system; they must be able to determine what their regulatory responsibilities will be and what expenses and programmatic changes those regulations will require. A severability remand would make that impossible. The hospitals would be left with an uncertain regulatory landscape as severability winds its way through the courts. They would face the possibility that dozens of statutory and regulatory requirements they have spent years implementing will disappear. And they would be reluctant to participate in innovative ACA programs designed to improve health care delivery.

For example, the ACA authorizes the Centers for Medicare and Medicaid Services ("CMS") to work with hospitals to implement "demonstration projects"—i.e., experimental care-delivery and payment models—that are exempt from many CMS regulations. *See, e.g.*, 42 U.S.C. § 1315a. The idea is to try innovative solutions to improve quality of care and reduce spending. But demonstration projects require substantial commitments of time and money to launch. Many hospitals have been reluctant to commit to them while the ACA's future remains uncertain; they cannot justify shouldering high start-up costs when the ACA could be struck down, and the demonstration terminated, before any improvements are realized. That is just one of many impediments this Court could remove by making the severability determination without a remand.

Second, protracted remand proceedings would encourage states uncertain about the wisdom of the ACA to procrastinate. Some states have taken a "wait-and-see approach" to implementing the ACA while their legal challenges wind through the courts. M. LaPointe, *Health Care Reform in Limbo*, Business NH Magazine (Oct. 5, 2011).[2] Thus, for example, while some have begun to design insurance exchanges, others are "waiting for * * * the judicial challenges to PPACA to be resolved." K. Koster, *In the Eye of the Storm*, Employee Benefit Adviser (Mar. 1, 2011).[3]

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[2] *Available at* http://millyardcommunications.com/index.php?src=news&srctype=detail&category=News&refno=2616.

[3] *Available at* http://eba.benefitnews.com/news/eye-storm-2685251-1.html.

Indeed, at least two states' governors "have already said no to an exchange in their state until the Supreme Court has its say[.]" *See* K. Nocera, *SCOTUS Causes States to Hit Pause*, Politico, Nov. 28, 2011.[4]

If the Court were to remand for further severability proceedings, and if past is prologue, the procrastination would continue and some states likely would miss the deadline to get their exchanges up and running by January 1, 2014. *See id.* (states are on a "tight timeline" to implement the ACA on schedule). The important project of health care reform should move forward.

2. At least one *amicus* suggested below that any severability determination should be made by the district court on remand. *See* Br. of the Chamber of Commerce in Support of Neither Party 26-28, Nos. 11-11021-HH & 11-11067-HH (11th Cir.). Such a remand would be counterproductive for the reasons just discussed. But it also is contrary to this Court's usual practice. The Court typically decides for itself the severability of federal statutes—even complex ones—where the question is squarely presented.

In *Alaska Airlines* v. *Brock*, for example, the Court found an invalid legislative veto severable from the intricate Airline Deregulation Act. 480 U.S. 678, 697 (1987). In *INS* v. *Chada*, the Court severed another invalid legislative veto from the even more complex Immigration and Nationalization Act. 462 U.S. 919, 923-925, 934-935 (1983). In *Free Enterprise Fund* v. *Public Company Accounting Oversight Board*, the Court severed an invalid tenure-protection provision from the remainder of Sarbanes-Oxley. 130 S. Ct.

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[4] *Available at* http://www.politico.com/politicopulse/1111/politicopulse631.html.

3138, 3161-3162 (2010). And in *United States* v. *Booker*, the Court carefully parsed the Sentencing Reform Act and found parts severable and other parts non-severable from an invalid enhanced-sentencing scheme. 543 U.S. 220, 259-265 (2005). Neither a law's length and complexity (*e.g.*, Sarbanes-Oxley) nor the interconnectedness of its provisions (*e.g.*, the Sentencing Reform Act) has deterred this Court from making the severability decision for itself.

To be sure, the Court occasionally has remanded for severability determinations. *See, e.g.*, *Exxon Corp.* v. *Eagerton*, 462 U.S. 176, 197 (1983) (remand to Alabama court); *Elfbrandt* v. *Russell*, 384 U.S. 11, 23 (1966) (remand to Arizona court). But in those cases, the law at issue was a *state* law. And the Court has made clear that the severability of a state law is itself "a question of state law to be addressed on remand," either by the state court or by the Court of Appeals, with its superior knowledge of state laws in its circuit. *United States Dep't of Treasury* v. *Fabe*, 508 U.S. 491, 509-510 (1993); *accord Metromedia Inc.* v. *City of San Diego*, 453 U.S. 490, 521 n.26 (1981). The lower courts' judgment as to the severability of a *federal* law is entitled to no similar deference. This Court should decide the question itself and avoid the uncertainty a remand would cause.

III. IF THE MANDATE FALLS, CERTAIN OF THE ACA'S MEDICARE AND MEDICAID FUNDING REDUCTIONS AND PENALTIES SHOULD FALL TOO.

"The inquiry into whether a statute is severable is essentially an inquiry into legislative intent." *Minnesota* v. *Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). And while courts will presume that constitutional portions of a statute should be "left intact," *Ayotte* v. *Planned Parenthood*, 546 U.S. 320, 329 (2006) (quotation marks omitted), they nevertheless must excise provisions that will no longer "function in a manner consistent with the intent of Congress" absent the invalid portion of the law. *Alaska Airlines*, 480 U.S. at 685.

Plaintiffs argue that the entire ACA meets this description and that the whole law must fall if this Court strikes down the individual mandate. The Hospital Associations strongly disagree. The ACA contains hundreds of provisions that would function just as Congress intended, and would improve health care delivery and extend coverage to millions of Americans, in the mandate's absence. Those provisions should be retained if the mandate falls.

There are, however, three Medicare- and Medicaid-related provisions—the Disproportionate Share Hospital reductions, readmissions program, and productivity and market-basket adjustments—that *should* be excised if the mandate is invalidated. Those provisions cut deeply into federal support for hospitals, reducing payments for the services hospitals provide by *more than $200 billion* over ten years.[5] And they are inextricably intertwined with the individual mandate. As we demonstrate below, the administration and Congress included them in the ACA on the explicit understanding that the mandate would "add millions of new consumers to the health insurance market," 42 U.S.C. § 18091(a)(2)(C), offsetting the loss of federal revenues for hospitals and allowing them to continue serving patients while still making ends meet. Without that understanding, the ACA would not have been enacted in its current form. Moreover, Congress explicitly linked some of the cuts to the mandate, making clear that it wanted them implemented only in a world where the mandate had sharply reduced the nation's uninsured rate.

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[5] *See infra* at 12 ($40 billion in DSH cuts); *id.* at 16 (at least $7.1 billion in readmissions penalties); *id.* at 22 (at least $156 billion in productivity adjustments and market-basket cuts).

These links between the mandate and the three Medicare and Medicaid provisions place the provisions in a different category than any others in the ACA. Without the mandate, the provisions would no longer "function in a manner consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. Congress's careful trade-offs would be undone, and the ACA transformed into a one-sided budget cut that would deeply harm hospitals and the patients they serve. Congress did not intend that result. If the mandate falls, these cuts should fall too.

A. DSH Cuts.

1. Medicare and Medicaid Disproportionate Share Hospital, or "DSH," payments provide assistance to safety-net hospitals that serve a large number of low-income patients, including the uninsured and those enrolled in Medicaid. National Health Policy Forum, *The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments* 1 (June 15, 2009) ("*The Basics*").[6] These payments are in addition to the regular payments that all hospitals receive for treating Medicare and Medicaid patients. They compensate safety-net hospitals for the cost of caring for the

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[6] *Available at* http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf.

uninsured and underinsured and help hospitals maintain the resources to care for those patients, many of whom have nowhere else to turn for medical assistance. L. Fishman & J.D. Bentley, *The Evolution of Support for Safety-Net Hospitals* 34-35, Health Affairs (July 1997).

The importance of DSH payments to inner-city and rural safety-net hospitals cannot be overstated. In 2009, the federal government allocated $11.3 billion for Medicaid DSH payments and $10.1 billion for Medicare DSH payments. *See* Health Industry Distributors Ass'n, *Disproportionate Share Hospital (DSH) Payments, Health Care Reform* 1 (Sept. 2010) ("*HIDA Report*").[7] These payments are the largest source of federal funding for uncompensated care and the largest source of public funding for many hospitals. *The Basics* 1. And they are necessary for safety-net hospitals to cover their costs: Absent Medicaid DSH payments, the average NAPH member hospital's margin in 2009 would have dropped from 2.5 percent to *negative* 5.5 percent. NAPH, *2009 Annual Survey: Safety Net Hospitals and Health Systems Fulfill Mission in Uncertain Times* 5-6 (Feb. 2011).[8] Without DSH payments—or something to replace them—many safety-net hospitals could not keep operating.

2. The ACA imposes deep cuts on both the Medicaid and Medicare DSH programs. Section 3133 of

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[7] *Available at* http://www.hida.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=13765.

[8] *Available at* http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2009-Characteristics-Survey-Research-Brief.aspx?FT=.pdf.

the Act, 42 U.S.C. § 1395ww(r), cuts Medicare DSH payments by 75 percent and then adjusts that number somewhat based on reductions in the number of uninsured. The cuts are estimated to reduce hospitals' Medicare DSH program by $22.1 billion over 10 years. *See* American Hospital Ass'n, *Summary of 2010 Health Care Reform Legislation* 34 (Apr. 19, 2010) ("*AHA 2010 Summary*").[9] Section 2551 of the ACA, 42 U.S.C. § 1396r-4(f)(7), in turn, reduces federal Medicaid DSH spending by $18.1 billion over 11 years. *AHA 2010 Summary* 35. That is a 50 percent reduction from 2009 funding levels. *See HIDA Report* 1.

3. The key point for severability purposes, however, is not that Congress cut DSH funding in the ACA; it is that Congress chose to do so *in reliance on the individual mandate*. Congress knew that the mandate would sharply reduce the number of uninsured Americans—by some 18 million people over and above what other ACA provisions would accomplish, according to one recent estimate. *See* M. Buttgens *et al.*, Robert Wood Johnson Foundation, *Why the Individual Mandate Matters* 3 (Dec. 2010) ("Buttgens").[10] And Congress expected that reduction to allow a transition from the current system of government payments to offset uncompensated-care costs—*i.e.*, DSH payments—to a system where formerly uninsured patients have insurance coverage and can pay for services themselves. As one member of Congress said in describing a similar change enacted in Massachusetts: "[T]hey said we are

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[9] *Available at* http://www.aha.org/advocacy-issues/tools-resources/advisory/2010/100419-legislative-adv.pdf

[10] *Available at* http://www.rwjf.org/files/research/71601.pdf.

giving all of this money to hospitals for disproportionate share payments, what if we just took that money and helped people buy insurance? *Everybody is insured, and then you don't need to provide the disproportionate share payments any longer*." 156 Cong. Rec. H2204 (daily ed. Mar. 22, 2010) (statement of Rep. Burgess) (emphasis added).

That intimate connection between the DSH cuts and the individual mandate is apparent in the statutory text itself and throughout the legislative history. To begin with the text: The ACA's Medicaid DSH provision sets forth defined annual DSH cuts—$5 billion in 2018, $5.6 billion in 2019, and so forth[11]—but instructs CMS to make two categories of states bear the brunt of those reductions: those with "the lowest percentages of uninsured individuals," and those that fail to direct their DSH grants to hospitals with the highest uncompensated-care levels. 42 U.S.C. § 1396r-4(f)(7)(B)(i). That is concrete evidence of Congress' intent to tie DSH cuts to the higher percentage of insured patients, and reduced uncompensated-care burden, that the individual mandate would bring. But without the mandate, Congress's careful balance would be undone: *All* states would have much higher uninsurance rates than Congress assumed, and *all* DSH hospitals would bear a much larger uncompensated care burden than Congress assumed—and yet the full $18.1 billion in Medicaid DSH reductions would remain in place. Congress' clear intent to tie DSH cuts to an increase in coverage would be foiled.

The Medicare DSH provision is to the same effect. That provision cuts Medicare DSH payments by 75 percent but then partially restores them with an additional payment based on the hospital's uncompensated-care load. 42 U.S.C. § 1395ww(d)(5)(F), (r)(1). And the formula for allocating additional payments is explicitly tied to Congress' assumptions about the rate of uninsured in a world with the individual mandate: Section 1395ww(r)(2) specifies that additional payments are to be calculated by multiplying three factors, and one of those factors is the decrease in the national uninsured rate from 2013 (the base year) to the year in question. *See id.*; *see also id.* § 1395ww(r)(2)(B). But Congress told CMS to calculate that decrease in the uninsured rate based on the Congressional Budget Office's 2010 predictions about how much the uninsured rate would drop each year *with the individual mandate*. *See id.* § 1395ww(r)(2)(B)(i). Absent the mandate, the uninsured rate would drop much less than Congress expected—and yet Medicare DSH payments would still be cut to levels that Congress thought appropriate for a world of near-universal coverage. Congress' choice to tie Medicare DSH cuts directly to the mandate's expansion of coverage shows that Congress would not have wanted the DSH cuts to stand if the mandate fell.

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[11] *See AHA 2010 Summary* 35.

The legislative history only underscores that Congress and the executive branch expected DSH payment reductions and mandate-driven insurance coverage to work in concert. President Obama explained the proposed DSH reductions this way: "As health reform phases in, *the number of uninsured will go down, and we would be able to reduce payments to hospitals for treating those previously uncovered.*" White House Fact Sheet, *Paying for Health Care Reform* (June 13, 2009) (emphasis added).[12] One of the House reports on what became the ACA anticipated that later in the decade, CMS would develop reports "discuss[ing] the extent to which there is a continued role for Medicaid DSH payments in light of the effectiveness of the health reforms * * * in reducing the number of uninsured individuals." H.R. Rep. 111-299, pt. 1, at 612 (2009). The House report on the reconciliation bill that gave the DSH cuts their final form anticipated further DSH payment reductions in 2017 "[i]f there is a significant decrease in the national rate of uninsurance as a result of this legislation[.]" H.R. Rep. 111-443, pt. 1, at 316 (2010). And the same report emphasized that *"[t]he committee is reluctant for any Medicare DSH cuts to go into effect until a drop in the uninsured rate occurs."* *Id.* (emphasis added).

These statements all drive at the same point: Congress understood that the deep DSH cuts included in the ACA made sense only in light of the mandate. Indeed, Congress even chose to *calculate* the DSH cuts on the assumption that the mandate would be in place. Without the mandate, but with the DSH cuts, hospitals serving the most vulnerable populations would be stripped of billions of dollars in funding, with a reduced prospect of income from privately insured patients to offset it. The safety net might not survive.

Congress could not have intended that result—and in fact, the statutory text and legislative history make clear that it did not. If the mandate falls, the DSH cuts must fall too.

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[12] *Available at* http://www.politico.com/politicopulse/0609/politicopulse12.html (follow "Read the Whole Post" hyperlink).

B. The Readmissions Program.

The ACA's readmissions reduction program, 42 U.S.C. § 1395ww(q), financially penalizes hospitals whose patients are readmitted after initial discharge at higher-than-expected rates. The penalties can be significant, costing a hospital up to 3 percent of its total Medicare reimbursements. *See id.* The Medicare Payment Advisory Commission, a government-sponsored advisory group, first proposed a readmissions program in its June 2007 report to Congress. *See* Medicare Payment Advisory Comm'n, *Report to the Congress: Promoting Greater Efficiency in Medicare* 111-14 (June 2007).[13] However, it was not until the ACA that Congress enacted the program, and attached financial penalties to it, as a way to press hospitals to further "enhance [the] quality of care" they provide. H.R. Rep. No. 111-299, pt. 2, at 339. Congress expected the penalties to save the federal government billions of dollars—some $7.1 billion, according to a recent estimate—over ten years. *See* N. Levey, *Hospitals Give Health Reform A Boost*, L.A. Times, July 9, 2009 ("Levey"); *see also AHA 2010 Summary* 27.

This indirect funding cut was part and parcel of the trade-off that undergirded all of the ACA's Medicare and Medicaid funding reductions, as we discuss in detail below: Congress recognized that hospitals could withstand the package of cuts if and only if the individual mandate helped offset the hospitals' lost federal revenues. *See infra* at 20-21; *see also* Levey, *supra* (hospitals agreed to $155 billion in Medicare and Medicaid cuts, including "savings * * * from new incentives for hospitals to prevent patients from having to be readmitted," on the condition that Congress "succeeded in extending health insurance to tens of millions of people who are now without coverage").

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[13] *Available at* http://www.medpac.gov/chapters/Jun07_Ch05.pdf.

But the readmissions program also is tied to the individual mandate in a second, related way. Enhancements necessary to reduce readmissions can be costly, both in terms of hospital resources and capital investment. Studies show that to achieve improvements in readmissions, hospitals must invest in new care-coordination and discharge procedures. *See* American Hospital Ass'n, *Examining the Drivers of Readmissions & Reducing Unnecessary Readmissions for Better Patient Care* 10 (Sept. 2011). New technologies have been shown to help. *See, e.g.*, *Overcoming Rural Health Care Barriers: Use of Innovative Wireless Health Technology Solutions: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs*, 111th Cong. 13, 24-25 (2010). But they, too, require a substantial source of funding.

Congress was well aware of these facts when it enacted the readmissions program. The ACA itself recognized that hospitals would need to "implement * * * comprehensive program[s] for hospital discharge," including "patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional," in order to "prevent hospital readmissions." 42 U.S.C. § 300gg-17(a)(1). Members of Congress spoke about the programmatic investments required to reduce readmissions, stating, for example, that hospitals had succeeded by "creating a transitional model that makes sure that when patients leave the hospital, they do so with a coach" who "helps them go from the emergency room to their primary care physician, their mental health provider, making sure they get the care they need over a period of time, making sure they don't forget their prescriptions[.]" 155 Cong. Rec. S13663 (daily ed. Dec. 21, 2009) (statement of Sen. Bennet); *see also* 155 Cong. Rec. S12135 (daily ed. Dec. 2, 2009) (statement of Sen. Whitehouse) (hospitals will need to "invest and improve on the front end" to avoid excess readmissions). And hospitals and other providers drove it home at Congressional hearings on readmissions, explaining that new care-coordination methods can reduce readmissions—but that Congress needed to "invest money in it" to make the goal a reality. *Achieving Health Reform's Ultimate Goal: How Successful Health Systems Keep Costs Low and Quality High: Hearing Before the S. Special Comm. on Aging*, 111th Cong. 110 (2009) (statement of Dr. Arnold Epstein).

Congress thus understood that hospitals—and especially resource-strapped hospitals, many of which serve urban or rural areas—can invest in programs that reduce readmissions only if they have the funds required to do so. The individual mandate, and its creation of a larger market of insured patients, helps provide those funds. Without the mandate, and with the readmissions program still in place, struggling hospitals will struggle more: They will be left with reduced Medicare payments and insufficient resources to replace them. That will hurt patients—particularly the minority and lower-income patients who often rely on safety-net hospitals for their care. *See* Kaiser Health News, *KHN Used CMS Readmission Rates And Patients' Income*

For Analysis (Dec. 19, 2011) (hospitals treating a higher proportion of low-income and minority patients "are more likely than others to have higher readmission rates").[14] Congress, with its overarching goal of "enhanc[ing] quality of care," H.R. Rep. No. 111-299, pt. 2, at 338-339, could not have intended that result.

C. The "Productivity Adjustment" And Market-Basket Cuts.

Finally, the ACA's so-called "productivity adjustment," 42 U.S.C. § 1395ww(b)(3)(B)(xi), and the related reduction in "market basket" rates, *id.* § 1395ww(b)(3)(B)(xii), should be excised if the mandate falls. The Obama administration and Congress included these massive funding cuts in the ACA--and representatives of the nation's hospitals agreed that they were financially feasible—on the express understanding that the individual mandate would help the hospitals offset their losses. Without the mandate, the productivity adjustment and market-basket cuts would not have been included in the legislation.

1. Congress provides Medicare payments to hospitals and other healthcare providers to compensate them for the services they provide to Medicare recipients. The ACA changes the formula used to calculate those payments in two significant ways. First, it reduces the Medicare update for inflation by a percentage pegged to the 10-year rolling average of productivity gains in the economy. 42 U.S.C. § 1395ww(b)(3)(B)(xi). Second, it reduces the "mar-

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[14] *Available at* http://www.kaiserhealthnews.org/Stories/2011/December/20/Readmissions-Methodology.aspx.

ket basket" rates used to annually adjust Medicare payments. *Id.* § 1395ww(b)(3)(B)(xii). The effect of these changes is to further divorce Medicare payments from the actual cost of services. As the cost of providing care increases over time, the payments to healthcare providers will not keep up.

2. The Congressional Budget Office estimated that the productivity adjustment and market-basket reductions will cut payments to providers by $156 billion over ten years, while CMS' actuary pegged the reduction at $233 billion. B. Semro, The Bell Policy Center, *Potential Impacts of New Federal Policies on Provider Reimbursement Rates* (Nov. 1, 2011).[15] These cuts are very large; hospitals with tight margins could not absorb such a substantial reduction in revenue without something to offset it.

Congress and the administration recognized as much. *See, e.g.*, 155 Cong. Rec. S11092 (Nov. 4, 2009) (statement of Sen. Grassley) (productivity adjustment "show[s] why there is genuine concern that health care for Medicare beneficiaries will suffer greatly because of health care reform"). That is why they publicly announced that hospitals would be asked to accept such cuts only on the understanding that the individual mandate would offset the loss. In July 2009, Vice President Biden announced that "three associations representing the hospital industry" had agreed to productivity and market-basket cuts, as well as the other provisions discussed above, "as part of a health overhaul *that assumes coverage of 95 percent of the American people.*" J. Reichard, *Biden Announces Deal With Hospitals to Cut Medi-*

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[15] *Available at* http://bellpolicy.org/content/potential-impacts-new-federal-policies-provider-reimbursement-rates.

care, Medicaid Payments by $155 Billion, CQ Healthbeat, July 8, 2009 (emphasis added) ("*Biden Article*").[16] Biden stated that the agreement "*calls for payments to be shaved as more patients treated by hospitals obtain coverage.*" *Id.* (emphasis added). AHA officials offered the same perspective on the cuts, stating that "hospitals had agreed to about $150 billion in savings after securing assurances that lower reimbursements would come after an insurance expansion that would guarantee that more patients pay their bills." D. Herszenhorn & S. Stolberg, *Health Deals Could Harbor Hidden Costs*, N.Y. Times, July 8, 2009.[17] And that agreement became the basis for a Senate Finance Committee markup that introduced the cuts into the ACA for the first time. *See Biden Article, supra; see also* S. 1796, 111th Cong. § 3401 (2009) (Senate Finance Committee bill linking cuts, in part, to levels of uninsured).

The productivity adjustment and market-basket cuts, in short, were justified by the individual mandate; without the mandate, they would never have been included in the legislation. Moreover, in their practical operation, the provisions are tied to the mandate. The ACA provides federal subsidies to help the uninsured pay for the coverage required by the mandate, and it uses the productivity adjustment and market-basket cuts to pay for those subsidies. *See, e.g.*, M. Janiszewsk, *Responding to Reform, 5*

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[16] *Available at* http://www.commonwealthfund.org/ Newsletters/Washington-Health-Policy-in-Review/2009/Jul/July-13-2009/Biden-Announces-Deal-with-Hospitals-to-Cut-Medicare-Medicaid-Payments-by-155-Billion.aspx.

[17] *Available at* http://www.nytimes.com/2009/07/08/health/policy/08health.html.

Strategies for Reinventing the Revenue Cycle, hfm Magazine (May 2011) (noting that "[f]unding to expand insurance coverage will come from Medicare and Medicaid cuts," with "[$]156 billion" in these cuts coming "through Medicare market basket productivity adjustments and reductions to the update factor").[18] In a world with no mandate, the subsidies would remain in place, but they would not be fully utilized because fewer uninsured individuals—some 18 million fewer—would seek coverage. *See* Buttgens 3. Healthcare providers thus would suffer a substantial reduction in Medicare reimbursements without *anyone* receiving the offsetting benefit those cuts were designed to fund.

* * *

The three provisions discussed above were at the heart of the ACA's grand bargain. Striking the mandate but retaining these provisions would unbalance the arrangement of benefits and burdens anticipated by Congress when it fashioned the ACA. The provisions would become a penalty with no offset; they no longer would "function in a manner consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. If the mandate falls, the three provisions should fall as well. To leave them in place absent the mandate would be a crippling blow for America's hospitals.

CONCLUSION

This Court should uphold the individual mandate. But if it strikes down the mandate it should make the decision regarding severability itself, without a remand, and it should find that the provisions discussed above are not severable from the mandate.

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[18] *Available at* http://www.hfma.org/Templates/Print.aspx?id=27057.

Respectfully submitted,

MELINDA REID HATTON
MAUREEN D. MUDRON
American Hospital
Association
325 Seventh Street, N.W.
Suite 700
Washington, D.C. 20001
(202) 638-1100

IVY BAER
FRANK R. TRINITY
Association of American
Medical Colleges
2450 N Street, N.W.
Washington, D.C. 20037
(202) 828-0499

JEFFREY G. MICKLOS
Federation of American
Hospitals
801 Pennsylvania Ave.
Suite 245
Washington, D.C. 20004
(202) 624-1521

SHEREE R. KANNER
CATHERINE E. STETSON*
DOMINIC F. PERELLA
MICHAEL D. KASS
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5491
cate.stetson@hoganlovells.com

BARBARA EYMAN, General
Counsel
National Association of Public
Hospitals and Health Systems
1301 Pennsylvania Ave., N.W.
Suite 950
Washington, D.C. 20004
(202) 585-0100

Counsel for Amici Curiae
**Counsel of record*

January 6, 2012

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

In The
Supreme Court of the United States

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NAT'L FEDERATION OF
INDEPENDENT BUSINESSES, ET AL.,

Petitioners,

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH
AND HUMAN SERVICES, ET AL.,

Respondents.

◆

STATE OF FLORIDA, ET AL.,

Petitioners,

v.

DEPARTMENT OF HEALTH AND
HUMAN SERVICES, ET AL.,

Respondents.

◆

On Writs Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

◆

BRIEF FOR *AMICI CURIAE* AMERICAN MEDICAL STUDENT ASSOCIATION; DOCTORS FOR AMERICA; NATIONAL HISPANIC MEDICAL ASSOCIATION; NATIONAL MEDICAL ASSOCIATION; NATIONAL PHYSICIANS ALLIANCE; AND SOCIETY OF GENERAL INTERNAL MEDICINE IN SUPPORT OF THE UNITED STATES ON SEVERABILITY

◆

IAN MILLHISER
CENTER FOR AMERICAN PROGRESS
1333 H St. NW, 10th Floor
Washington, DC 20005
(202) 481-8228
imillhiser@americanprogress.org
Attorney for Amici Curiae

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

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INTERESTS OF *AMICI CURIAE*[1]

Amici are diverse health care provider organizations representing tens of thousands of health care professionals throughout the country. *Amici* believe that the Affordable Care Act is a significant achievement for the patients that their members serve because it ensures greater protection against losing or being denied health insurance coverage. It promotes better access to primary care and to wellness and prevention programs. It helps ensure that all areas of the nation have adequate access to health providers, and it enables essential research that allows health providers to better treat their patients.

Because *amici*'s members work throughout the continuum of care and in all settings within the health care industry – from direct care to hospital administration – *amici* have a uniquely broad and informed perspective on the impact of the Affordable Care Act. Specifically, they have the capacity to offer an expert perspective on how multiple goals – ranging from ensuring that patients can afford care to ensuring adequate access to providers to ensuring that those providers are well-informed about the most effective ways to treat their patients – are advanced by the Affordable Care Act, and to explain why Congress would not have wanted any of these goals to be left unaddressed.

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *amici*, its members or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of *amicus* briefs and have filed letters reflecting their blanket consent with the Clerk.

◆

SUMMARY OF ARGUMENT

Especially in light of Private Petitioners' admission that the Patient Protection and Affordable Care Act's, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA") minimum coverage provision is an essential element of the ACA's broader regulation of the health insurance market, this Court should not reach the severability question. Private Petitioners claim that the minimum coverage provision "works to counteract the powerful inflationary impacts" of the ACA's insurance regulations, "which would otherwise make premiums in the individual insurance market prohibitively expensive." NFIB Brief at 36-37.[2] This and other arguments presented in their brief on severability constitute an outright admission that the minimum coverage provision is an "essential part of a larger regulation of economic activity," and thus must be upheld under Congress' Commerce and Necessary and Proper powers. *Gonzales v. Raich*, 545 U.S. 1, 17

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[2] This brief will refer to the Brief for Private Petitioners on Severability as the "NFIB Brief" and the Brief for State Petitioners on Severability as the "States Brief."

(2005) (quoting *United States v. Lopez*, 514 U.S. 549, 561 (1995)).

Should this Court reach the severability issue, however, its inquiry should be bound by both the constraints of judicial modesty articulated in longstanding precedents and by Congress' decision to expressly draw an outer bound around the severability inquiry in this case. Because the balance of the Affordable Care Act would remain "fully operative as a law" even if the minimum coverage requirement were excised, this Court's precedents establish an unusually strong presumption in favor of severability. This Court "must sustain" the balance of the law "'[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid].'" *Free Enterprise Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quoting *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987)) (alterations in original).

It is not at all "evident" that Congress would not have enacted the lion's share of the ACA absent a minimum coverage provision. To the contrary, Congress' express findings place an outer bound around the scope of this Court's severability inquiry should it accept Petitioners' novel challenge to the minimum coverage requirement. Congress explicitly states in the ACA's findings that only those provisions of the ACA which ensure that "health insurance products . . . are guaranteed issue and do not exclude coverage of pre-existing conditions" are linked to the minimum coverage provision. ACA § 10106(a). This finding is powerful evidence that Congress did not believe that the balance of the law should not exist in the absence of a minimum coverage provision. *See Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 174 (1803) ("Affirmative words are often, in their operation, negative of other objects than those affirmed. . . .")

Additionally, Petitioners misread the ACA as solely focused on a "core" or "single central" goal of expanding access to affordable health insurance coverage. NFIB Brief at 46; States Brief at 54. While this is, indeed, an important purpose behind the ACA, the law also serves equally important purposes such as ensuring that underserved regions and populations have sufficient access to health providers, encouraging more physicians to enter general family practice or general pediatric practice, enabling nurses to take a greater leadership role in providing medical services, and improving health outcomes by fostering research into medical best-practices. It is not "evident" that Congress would have preferred not to address these issues if it could not have enacted the ACA in its entirety.

◆

ARGUMENT

I. PRIVATE PETITIONERS' SEVERABILITY ARGUMENTS ARE A LENGTHY CONCESSION THAT THE MINIMUM COVERAGE PROVISION IS AN "ESSENTIAL PART OF A LARGER REGULATION OF ECONOMIC ACTIVITY," AND THEREFORE CONSTITUTIONAL

When an individual provision of law is an "essential part of a larger regulation of economic activity," it fits within Congress' enumerated authority under the Commerce and Necessary and Proper Clauses even if that provision could not have been enacted as a stand-alone law. ***Raich***, 545 U.S. at 17. The minimum coverage provision easily clears this bar because, as Congress explained, such a provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." ACA § 10106(a).

Private Petitioners, however, allege that the minimum coverage provision is an even more essential element of the Affordable Care Act's regulation of the health care and health insurance markets than Congress believed it to be. To reach the conclusion that invalidating the minimum coverage provision necessarily requires this Court to invalidate the entire Act, Private Petitioners play an elaborate game of "the house that Jack built" that begins by demonstrating that Congress correctly determined that the minimum coverage provision is essential to many of the ACA's insurance reforms. By the time they are done building this house, they have not only conceded that the minimum coverage provision is essential to those insurance reforms identified by Congress, Private Petitioners have also claimed that the minimum coverage provision is an essential part of the ACA's larger regulation of employment and of its health insurance exchanges – which themselves regulate trade in health insurance.

- *First*, Private Petitioners begin their argument by admitting that the minimum coverage provision is an essential part of the ACA's larger regulation of insurers' interactions with patients who have preexisting conditions. As Private Petitioners concede, the minimum coverage provision "works to counteract the powerful inflationary impacts" of the ACA's insurance regulations, "which would otherwise make premiums in the individual insurance market prohibitively expensive." NFIB Brief at 36-37. Thus, Private Petitioners agree with Congress' determination that the minimum coverage provision is an essential part of a larger regulation of economic activity.
- *Second*, having effectively conceded the constitutionality of the minimum coverage provision, *Raich*, 545 U.S. at 17, Private Petitioners then argue that the minimum coverage provision is essential to the Act's subsidies for consumers in the individual health insurance market. According to Private Petitioners, the "powerful inflationary

impacts" that would result without a minimum coverage provision would render those subsidies prohibitively expensive. NFIB Brief at 49-50. Having thus attempted to undermine the subsidies, Private Petitioners then link the minimum coverage provision to two other regulations of economic activity.

- *Third*, Private Petitioners argue that the minimum coverage provision is an essential element of the ACA's regulation of employment. The ACA's employer responsibility provision regulates employment by imposing a monetary assessment on large employers who do not provide a minimum degree of health benefits to their full-time employees who qualify for subsidies within the individual market. ACA § 4980H. Private Petitioners, however, claim that this provision "is inextricably intertwined with the subsidies described above." NFIB Brief at 51. Because they have previously claimed that the minimum coverage provision is essential to the subsidies, their attempt to link the employer responsibility provision to the minimum coverage provision is an argument that the latter is an essential part of a broader regulatory scheme that includes the former.

- *Finally*, Private Petitioners link the minimum coverage provision to the ACA's provisions creating regulated health insurance exchanges. These exchanges, Private Petitioners argue, also require the subsidies to function because "[w]ithout the subsidies driving demand within the exchanges

> insurance companies would have absolutely no reason to offer their products through exchanges, where they are subject to far greater restrictions." *Id.* at 51-52. Because Privative Petitioners have already claimed that the minimum coverage provision is essential to these subsidies, they effectively argue that it is an essential element of the exchanges' regulation of the health insurance market.

This Court need not accept each link in this increasingly attenuated chain in order to recognize the significance of the Private Petitioners' concession.[3] It is only necessary to recognize that the very first link of this chain admits that Congress correctly found the minimum coverage provision to be an essential part of a larger regulation of economic activity. Should this Court agree with the Private Petitioners' severability argument, then it will not be necessary for the Court to even reach the severability question because the Private Petitioners' assertions necessarily lead to the conclusion that the minimum coverage provision is constitutional. *See Raich*, 545 U.S. at 17; *Lopez*, 514 U.S. at 561.

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[3] Indeed, the second link in this chain rests upon a factually inaccurate assumption. The only reason why premium inflation will occur in the absence of a minimum coverage provision is because, in the absence of such a provision, the ACA's insurance regulations permit individuals to wait until the moment they become ill or injured to purchase insurance and then draw benefits from an insurance pool they have not paid into – a phenomenon known as "adverse selection." *See* Brief for *Amici Curiae* American Nurses Association, *et al.* on the Minimum Coverage Provision at 12. Absent those insurance regulations, adverse selection will not occur and thus insurance premiums will not increase.

II. PETITIONERS' SWEEPING CALL TO INVALIDATE THE ENTIRE ACA CANNOT BE SQUARED WITH THIS COURT'S PRECEDENTS REQUIRING JUDICIAL MODESTY

This Court's precedents establish two presumptions, both of which favor the Affordable Care Act. First federal courts are "obliged . . . to presume that acts of Congress are constitutional." *Seven-Sky v. Holder*, 661 F.3d 1, 18 (D.C. Cir. 2011) (citing *United States v. Morrison*, 529 U.S. 598, 607 (2000)). Thus, this Court should uphold the minimum coverage provision so long as "Congress had a rational basis for believing that failure" to enact this provision "would leave a gaping hole" in the ACA's economic regulatory scheme. *Raich*, 545 U.S. at 22.

In the context of severability, the ACA enjoys an even stronger presumption in favor of leaving laws largely intact. "[T]he 'normal rule' is that 'partial, rather than facial, invalidation is the required course,' such that a 'statute may . . . be declared invalid to the extent that it reaches too far, but otherwise left intact.'" *Ayotte v. Planned Parenthood of Northern New Eng.*, 546 U.S. 320, 329 (2006) (quoting *Brockett* v. *Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)). Because the balance of the Affordable Care Act would remain "fully operative as a law" even if the minimum coverage requirement were excised, the presumption in favor of severability is particularly strong – this Court "must sustain" the balance of the law "'[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid].'" *Free Enterprise Fund*, 130 S. Ct. at 3161 (quoting *Alaska Airlines*, 480 U.S. at 684) (alterations in original).

Thus, when this Court considers a law's constitutionality, judicial modesty counsels against "infring[ing] on traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy." *Turner Broadcasting Sys. v. FCC*, 520 U.S. 180, 196 (1997). Likewise, when this Court does conclude that a provision of law exceeds Congress' authority, the same judicial modesty counsels against "nullify[ing] more of a legislature's work than is necessary, for we know that '[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people.'" *Ayotte*, 546 U.S. at 329 (quoting *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion)).

Petitioners, however, ask the Court to cast such modesty aside. They ask this Court to cast a skeptical eye upon Congress' determination that the minimum coverage provision is an essential part of a larger regulation of the health insurance market for purposes of determining whether the minimum coverage provision exceeds Congress' enumerated powers, then immediately turn around and claim that the provision's tentacles reach so deeply into the

ACA's foundation that the entire statute must be cast aside. Simply put, Petitioners cannot have it both ways.

With respect to the question of constitutionality, Petitioners urge this Court to affirm a decision which determined that the minimum coverage provision is not essential to the ACA's insurance regulations because the Eleventh Circuit believed that this provision does not include a sufficiently effective enforcement mechanism. *See Florida v. U.S. Dept. of Health & Human Services*, 648 F.3d 1235, 1311 (11th Cir. 2011). The wealth of empirical evidence contradicting this determination is ably documented by an *amicus* brief submitted on the minimum coverage question currently before this Court, *see* Brief of American Association of People with Disabilities, *et al.* as *amicus curiae* (minimum coverage provision) 18-26, and does not need to be restated here. It should be noted, however, that the Eleventh Circuit's decision to substitute its own policy judgment about the efficacy of a federal statute for that of Congress "looks startlingly like strict scrutiny review," *Florida*, 648 F.3d at 1343 (Marcus, J., dissenting), and cannot be reconciled with the judicial modesty urged by this Court's precedents.

Petitioners' severability arguments similarly urge this Court to abandon its modest role and "frustrate[] the intent" of elected representatives in Congress by invalidating the product of more than a year of legislative effort. This urging not only requires the Court to turn on a dime from considering the minimum coverage provision to be ineffective and insignificant for purposes of constitutionality to suddenly deem it to be the keystone that holds the entire law together for purposes of severability, it also ignores what may be one of the strongest presumptions that exists in all of U.S. law. This Court may not invalidate any portion of the ACA which it deems constitutional unless it is "evident" that Congress would not have enacted those provisions independent of the provisions this Court deems unconstitutional. *Free Enterprise Fund*, 130 S. Ct. at 3162.

The word "evident" indicates that this Court must have a very high degree of certainty regarding Congress' preference before it invalidates an entirely constitutional provision of law. *See* American Heritage Dictionary of the English Language, *American Heritage Dictionary Entry: Evident* at http:// ahdictionary.com/word/search.html?q=evident ("Easily perceived or understood; obvious"). Yet it is far from clear what Congress would have enacted had it believed this Court would embrace the novel constitutional theory advanced by Petitioners. Even the State Petitioners, who admit that their proposed inquiry is "inherently counterfactual and speculative," concede this point. States' Brief at 57. If the result of an inquiry inherently relies upon speculation, then the proper outcome of that inquiry is, almost by definition, not "evident."

As Private Petitioners correctly point out, "if the severability analysis really must proceed provision-by-provision, courts would be faced with the impractical, unrealistic task" of combing through a lengthy statute and ruling on the continued viability of each provision. NFIB Brief at 55. This argument, however, does not lead to the conclusion Petitioners suggest. Rather, this Court has already made allowances for the unwieldiness of such a task by applying such a heavy presumption in favor of severability. By requiring Petitioners to overcome an unusually high bar in order to remove any constitutional provision from the bill, this Court's precedents already insulate the judiciary from the "unrealistic task" of combing line by line through an Act of Congress.

More importantly, Petitioners' briefs demonstrate why this Court's strong presumption in favor of judicial modesty in severability cases is wise, not only because it prevents severability cases from becoming a Sisyphean enterprise, but also because it prevents the judicial branch from engaging in inquiries that it is ill-suited to perform. Petitioners ask this Court to weigh such extraneous factors as the potential impact of insurance industry lobbyists on lawmakers' decisions, States' Brief at 9; NFIB Brief at 2, whether, given the choice between retaining provisions that shrink the budget deficit or losing the entire law, Congress would prefer more federal debt to less, States' Brief at 55, or the impact of Congressional procedural rules on attempts to amend the law, NFIB Brief at 59-61. It is difficult to imagine questions that are more clearly political in nature than how much influence a particular interest group has upon a particular legislative debate, or how large the federal government's budget deficit should be.[4] Similarly, any attempt by this Court to interpret Congress' own rules of proceeding raises serious concerns that the judiciary is intruding upon an area that is textually committed to another branch of government. *See* U.S. Const. Art. I, § 5 ("Each House may determine the rules of its proceedings. . . .")

Just as this Court's precedents require it to treat Acts of Congress with a presumption of constitutionality in order to avoid judicial intrusion into areas beyond the judiciary's competence, the strong presumption in favor of severability serves a similar role. Without either, the Court runs the risk of substituting its preferences for those of men and women who are chosen by the people to govern. Ultimately, Petitioners ask this Court to ignore both of these presumptions in order to "frustrate[] the intent of the elected representatives of the people." *Ayotte*, 546 U.S. at 329. The Court should not take them up on this invitation.

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[4] Indeed, at a recent Senate Judiciary Committee hearing, Justice Scalia laughed openly at the suggestion that judges play a role in "making budgetary choices" responding that "of course it's not" their proper role to do so. *Considering the Role of Judges Under the Constitution of the United States*, 112th Cong. (Oct. 5, 2011) at http://www.judiciary.senate.gov/hearings/hearing.cfm?id=8bbe59e76fc0b6747b22c32c9e014187.

III. PETITIONERS' PROPOSED ANALYSIS FRUSTRATES CONGRESS' EXPRESS INTENT AND IGNORES THE ACA'S DIVERSE PURPOSES

The Affordable Care Act is not, as State Petitioners suggest, single-mindedly focused on the "central goal of buying and paying for 'near-universal coverage,'" States' Brief at 54 (quoting ACA § 1501(a)(2)(D)), although achieving such coverage is indeed a purpose of many parts of the ACA. Rather, the Act recognizes that America's health care system faces a diversity of challenges that must be addressed in addition to the problem of uninsurance. As explained in detail below, a short list of the ACA's purposes includes ensuring that underserved regions and populations have sufficient access to health providers, encouraging more physicians to enter general family practice or general pediatric practice, enabling nurses to take a greater leadership role in providing medical services, and improving health outcomes by fostering research into medical best-practices. Even if this Court were to strike down the entirety of the law's provisions expanding access to health insurance coverage, it is not the least bit "evident" that Congress would have preferred for rural areas to have inadequate access to health professionals or for patients to receive expensive and unreliable treatments in the absence of the ACA's provisions expanding insurance coverage.

Lest there be any doubt, however, there is also no support for Petitioners' suggestion that this Court must sweepingly invalidate the ACA's coverage-expanding provisions if the minimum coverage provision should fall. To the contrary, the ACA's findings expressly preclude the result Petitioners suggest.

A. The ACA's Findings Expressly Place An Outer Limit On This Court's Severability Inquiry

Both State and Private Petitioners attempt to weave elaborate webs linking the minimum coverage provision to the ACA's entire apparatus for expanding access to the health insurance market. *See supra* Part I; States' Brief at 54. It is not necessary, however, for this Court to even consider whether these webs actually exist. This is because, as Petitioners repeatedly remind this Court in their briefs, "[t]he inquiry into whether a statute is severable is essentially an inquiry into legislative intent," *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999), and Congress expressly placed an outer limit on this Court's severability inquiry in the ACA's text.

Congress explicitly states in the ACA's findings that only those provisions of the ACA which ensure that "health insurance products . . . are guaranteed issue and do not exclude coverage of pre-existing conditions" or which create "effective health insurance markets that do not require underwriting and eliminate its associated administrative costs" are linked to the minimum coverage provision. ACA § 10106(a). Especially in light of the strong presumption favoring severability, *Free Enterprise Fund*, 130 S. Ct. at 3162, Congress' statement that only provisions related to specific, limited purposes depend on a minimum coverage provision to function is powerful evidence that it did not believe that the balance of the law should not exist in the absence of a minimum coverage provision. *See Marbury*, 5 U.S. (1 Cranch) at 174 ("Affirmative words are often, in their operation, negative of other objects than those affirmed. . . .") Because Congress expressly stated which provisions it might not have enacted if it could not have also enacted a minimum coverage provision, that express statement of legislative intent must define the outer limits of this Court's severability inquiry.

B. Petitioners Misstate The Purpose of The ACA's Provisions Which Are Irrelevant To Insurance Coverage

In addition to exceeding these congressionally-defined outer limits, Petitioners attempt to minimize the significance of what Private Petitioners refer to as the "menagerie of tag-along provisions that will remain" after the ACA's "pillars" are removed. NFIB Brief at 55. As both Private and State Petitioners read the statute, the ACA's "core" or "single central" goal is expanding access to affordable health insurance coverage, *id.* at 46; States Brief at 54, and the hundreds of pages of legislative text which are irrelevant to this goal must not be something Congress would have preferred to be law in the absence of a minimum coverage provision. This reading of the law, however, minimizes both the complexity of the health care system and the diverse array of problems the ACA was enacted to address.

Drastically reducing the problem of uninsurance is, indeed, one of the problems the ACA is intended to address. Approximately 50 million non-elderly Americans are uninsured, Kaiser Family Foundation, *The Uninsured: A Primer* 1 (Oct. 2011), a problem which resulted in more than 44,000 deaths in 2005. Likewise, sixty-two percent of all personal bankruptcies are caused in part by medical expenses, ACA § 10106(a), and thousands of workers forgo a new job opportunity or the chance to start a business because they cannot afford to leave a job that provides them with health insurance. Kevin T. Stroupe, *et al.*, *Chronic Illness and Health Insurance Related-Job Lock*, 20 J. Pol'y Analysis & Mgmt. 525, 525 (2001). Congress intended the ACA's insurance coverage provisions address these issues.

Yet inadequate access to health insurance is far from the only problem facing the American health care system. America must also have enough doctors, nurses and other medical professionals to meet the needs of ill or injured patients. Likewise, those professionals must be adequately distributed throughout the nation to enable patients in underserved areas to still obtain care. Care delivery models that rely excessively on expensive medical specialists not only drive up the cost of care, they often lead to inferior health outcomes than could be achieved with greater access to primary care providers. Finally, medical professionals often prescribe care that is ineffective or even harmful to their patients because they lack adequate research informing them of the most effective treatments for a particular medical condition. If America were to achieve universal insurance coverage tomorrow, but remain inadequate to the task of solving these remaining problems, then thousands of Americans would continue to die or suffer other avoidable health consequences each year despite their perfect access to insurance.

The ACA contains provisions addressing each of these issues, all of which function completely independently of the law's insurance coverage provisions. It is not at all "evident" that Congress would have chosen to leave unaddressed each of these separate and independent problems facing the nation's health care system had it believed that just one component of its preferred method of achieving near-universal coverage was off the table.

Access to health professionals: Despite the central role that the problem of uninsurance plays in the rhetoric surrounding health policy, significantly more Americans are impacted by shortages of health professionals than are by a lack of insurance. In 2007, nearly 64.5 million individuals lived in regions designated a "Health Professional Shortage Area" (HPSA) – a designation the Secretary of Health and Human Services may apply to regions where the ratio of residents to primary care physicians exceeds 3,000 to 1, 42 CFR Pt. 5 Appendix A(I)(D) – and 96 million people resided in regions designated under the somewhat more expansive definition for "Medically Underserved Areas" (MUA). Sara Rosenbaum, *et al.*, *George Washington Univ. Sch. of Public Health and Health Servs., National Health Reform: How Will Medically Underserved Communities Fare?* 2 (July 9, 2009). Seventy-two percent of residents in Medically Underserved Areas were insured in 2006. *Id.* at 4.

In some of these regions, health provider shortages are so intense that it is virtually impossible to obtain care. According to a 2008 report, three neighboring counties in Texas have not had a single medical doctor for more than twenty years. Tim Weldon, Council of State Governments, *Physician Shortages and the Medically Underserved* 1 (August 2008). Fully one-third of Idaho's counties are designated HPSAs, but even states that are rich with medical professionals include pockets of shortage. *Id.* Massachusetts has the most physicians per capita of any state in the nation, but only three of these physicians serve Nantucket County – one-third of what it should have according to the federal Health Resources and Services Administration. *Id.* These shortages result in "longer waits in busier doctors' offices, increased travel times to see physicians, less exposure to preventive strategies and poorer outcomes following traumatic injuries and illnesses." *Id.*

Many Americans also lack access to adequate nursing care. Beginning in 1998, the United States entered a decade-long nursing shortage that peaked when "hospital nurse vacancy rates reached a national average of 13 percent and an estimated 126,000 full-time-equivalent (FTE) RN positions were unfilled, forcing many hospitals to close nursing units and restrict operations." Peter I. Buerhaus, *et al.*, *The Recent Surge in Nurse Employment: Causes and Implications*, Health Affairs w657 (2009). Although this shortage started to abate during the recent recession, *id.*, there are worrying signs that these gains are unsustainable. In 1983, approximately 50 percent of the nursing workforce was between the ages of 20 and 34, while only 17 percent was over 50. By 2009, however "the number of nurses over age 50 more than quadrupled, and the number of middle-aged nurses (aged 35-49) doubled to approximately 39 percent (977,000). These older and middle-aged nurses now represent almost three-quarters of the nursing workforce, while nurses younger than 34 now make up only 26 percent." Institute of Medicine, *The Future of Nursing*: *Leading Change; Advancing Health* 125 (2011) ("Future of Nursing"). In part because of looming retirements caused by an aging nursing workforce, America is projected to experience a shortage of 260,000 registered nurses by 2025. *Id.* at 258.

Several provisions of the ACA address the problem of inadequate access to health professionals. The Act expands an existing Nursing Student Loan Program, § 5202 and enables grants to improve the training and retention of nurses, § 5309. It provides loan repayment to pediatric physicians who commit to practice in underserved areas, § 5203, and expands a scholarship program for disadvantaged health professional students from schools with a demonstrated record of placing graduates in medically underserved communities. § 5402(b). Additionally, it creates a commission that provides annual reports making recommendations to Congress "concerning national health care workforce priorities, goals, and policies" so that Congress can be well-informed about how to address health provider shortages in the future. § 5101(d)(2). It is not "evident" that Congress would not have enacted these provisions in the absence of a minimum coverage provision.

Fostering primary care: Primary health care providers play an essential role in achieving positive health outcomes. Primary care providers exist to evaluate their patients' health generally, and thus are prone to discover a health concern that has not yet been recognized by the patient, Institute of Medicine, *Primary Care: America's Health in a New Era* 53-54 (1996), and could be missed by a specialist who is not accustomed to evaluating patients holistically. Similarly, while patients typically seek specialty care to treat discrete medical conditions, primary care providers enjoy an "ongoing relationship" with their patients. *Id.* at 56. This lasting relationship not only fosters trust between the patient and the provider, it also enables primary care providers to familiarize themselves with the patient's health history and thus make treatment decisions that are informed by intimate details specific to each patient. *Id.*

A relationship with a primary care provider is particularly important for patients with chronic conditions. Such patients often must "modify[ ] their behavior, monitor[ ] their condition and participat[e] in treatment regimens" in order to keep their condition under control. Institute of Medicine, *Care Without Coverage: Too Little, Too Late* 57 (2002). Such tasks require patients to develop a complex understanding of their condition and to master tasks that do not come naturally to persons without education or training in the health sciences. Thus, a patient's continuing relationship with a single provider who can answer their questions and monitor their care is "a key to high-quality health care" for persons with chronic conditions. *Id.*

Yet, despite the crucial role played by primary care providers, our current system discourages new medical graduates from becoming such providers. One survey of medical students found that only 2 percent plan careers in general internal medicine. Future of Nursing at 257. Doctors practicing internal or general pediatric medicine earned approximately one quarter of the salary earned by the highest paid specialists in their first year out of residency. Laura Yao, *How Much Do Rookie Doctors Make? The Latest Scorecard*, Wall Street Journal (June 17, 2009). New primary providers earn approximately half what new anesthesiologists earn, and as much as $97,500 less than neurologists. *Id.* Over the course of a career in primary care, the average physician will earn $2.5 million less than if they had become a cardiologist. Shirley S. Wang, *Study: Primary Care Career Wealth*

Gap Totals Over $2.5 Million, Wall Street Journal (May 4, 2010).

Moreover, as this pay gap discourages new medical doctors from becoming primary care providers, the growing shortage makes the job increasingly difficult for those primary care providers who remain. The smaller pool of primary care providers must handle a larger and larger slate of patients in order to keep up with demand. As a result, primary care providers "are aptly compared to hamsters on a treadmill, struggl[ing] to provide prompt access and high-quality care." Thomas Bodenheimer, *et al.*, *A Lifeline for Primary Care*, 360 New England J. of Med. 2693, 2693 (2009). Worse, as the quality of primary care providers' work life diminishes, "the work-related stresses felt by primary care physicians tags primary care as the career with more work at less pay." *Id.* The result is a vicious cycle where primary care is viewed as an increasingly less desirable career path, which diminishes the pool of doctors willing to pursue this path, which in turn makes the path less desirable.

One positive trend that could provide a counterbalance to this shortage of primary care physicians is the emergence of alternative models for primary care providers. Today, approximately 83,000 nurse practitioners work as primary care providers, totaling just under one quarter of the nation's primary care professionals, and the number of health professionals who become primary care nurse practitioners is trending upward. Future of Nursing at 88.

The ACA contains several provisions that encourage medical graduates to pursue a career in primary care or provide new opportunities for nurse-driven care models. As mentioned above, one provision provides loan repayment to pediatric physicians who practice in underserved areas, including pediatricians who provide primary care. § 5203. The ACA also authorizes grants to train additional physicians in the fields of family medicine, general internal medicine and general pediatrics. § 5301. And it authorizes grants to nurse-managed health clinics that are managed by advanced practice nurses such as nurse practitioners and "provide[s] primary care or wellness services to underserved or vulnerable populations." § 5208. It is not "evident" that Congress would not have enacted these provisions absent a minimum coverage provision.

Comparative effectiveness research: Medicine is, at its heart, a science. It relies upon observing the impact of various possible treatments in order to assess which therapies are appropriate to treat which conditions. The ability to weigh data from thousands of patients in order to determine how best to provide care is what separates modern health providers from their forebearers who relied upon bloodletting and leeches.

Yet, in many cases, health providers lack access to cutting edge research which would give them the information they need to save lives or avoid unnecessary complications from outdated treatments. For this reason, the use of less effective, ineffective or even harmful treatments is surprisingly common.

In the 1990s, for example, it was common for women with metastatic breast cancer to be treated with high-dose chemotherapy instead of the standard treatment which relied on much lower doses. Michael S. Lauer, Commentary: *Will Academia Embrace Comparative Effectiveness Research?*, 86 Academic Medicine 671, 671 (2011). The side effects of these high doses are horrific, requiring an invasive transplant subsequent to treatment in order to replace bone marrow damaged by the toxic chemotherapy drugs, and yet it is estimated that more than 30,000 women received this treatment at a cost of $3 billion. *Id.* In 2000, a study in the *New England Journal of Medicine* revealed that "[t]he median survival in the group treated with high-dose chemotherapy and stem cells was 24 months, with a 3-year survival rate of 32 percent. The median survival in the conventional-chemotherapy group was 26 months, with a 3-year survival rate of 38 percent." Edward A. Stadtmauer, *et al.*, *Conventional-Dose Chemotherapy Compared With High-Dose Chemotherapy Plus Autologous Hematopoietic Stem-Cell Transplantation for Metastatic Breast Cancer*, 342 New England J. of Med. 1069, 1073 (2000). For years, doctors had treated their patients with enormous doses of toxic chemicals, only to learn that, if anything, this painful treatment produced slightly worse health outcomes than the alternative.

Nor was this experience with high-dose chemotherapy an isolated incident. A seminal 2003 study examined the health outcomes of over one million Medicare patients treated for hip fractures, colorectal cancer or heart attacks in hospitals nationwide. Elliott S. Fisher, *et al.*, *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality and Accessibility of Care*, 138 Annals of Internal Medicine 273, 273 (2003). It divided each of the patients into five groups depending on the amount of Medicare spending in the area where they were treated. Medicare spent, on average, only 61 percent as much on patients in the lowest quartile as it spent on those in the top quartile, *Id.* at 276, and patients in the highest spending regions received about 60 percent more care than those in the lowest spending regions. Once again, the patients who received the greatest amount of treatment experienced slightly worse health outcomes than those in the lowest spending areas. Elliot S. Fisher, *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 Annals of Internal Medicine 288, 293 (2003). The upshot of this study is that every day, hundreds of health providers in the higher treatment regions administered tests, proscribed drugs and provided other therapies that had no visible impact on their patients' health. The study's authors concluded that

> If the United States as a whole could safely achieve spending levels comparable to those

> of the lowest-spending regions, annual savings of up to 30% of Medicare expenditures could be achieved. Such savings could provide the resources to fund important new benefits, such as prescription drugs or expanded Medicare coverage to younger age groups, or to extend the life of the Medicare Trust Fund to better cover the health care needs of future retirees.

Id. at 298.

In order to improve patient outcomes and reduce the cost of care, the ACA authorizes a newly-created non-profit corporation entitled the "Patient-Centered Outcomes Research Institute" to draw funds from a federally-funded trust fund. § 6301(a). The new Institute shall "advanc[e] the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed. . . ." *Id.* In other words, the Institute seeks to produce research such as the seminal chemotherapy study which taught health providers to stop using a treatment that was both expensive and painful without achieving improved health outcomes. If it succeeds in doing so, it will drive down the cost of care while simultaneously achieving better health outcomes for patients across the nation.

It is not "evident" that Congress would have preferred not to create this Institute absent a minimum coverage provision.

◆

CONCLUSION

Because the Affordable Care Act is entirely constitutional, this Court should not reach the severability question. Should it do so, however, the Court should respect the outer limits on that inquiry as laid out in Congress' express findings, and allow the bulk of the ACA to be implemented.

Respectfully submitted,

IAN MILLHISER
CENTER FOR AMERICAN PROGRESS
1333 H St. NW, 10th Floor
Washington, DC 20005
(202) 481-8228
imillhiser@americanprogress.org
Attorney for Amici Curiae

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

In the
Supreme Court of the United States

NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, *et al.*,
Petitioners,

v.

KATHLEEN SEBELIUS, SECRETARY
OF HEALTH AND HUMAN SERVICES, *et al.*,
Respondents.

STATE OF FLORIDA, *et al.*,
Petitioners,

v.

UNITED STATES DEPARTMENT OF
HEALTH & HUMAN SERVICES, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF OF AMERICAN PUBLIC HEALTH ASSOCIATION, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN LUNG ASSOCIATION, AMERICAN SCHOOL HEALTH ASSOCIATION, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS, NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, NATIONAL HEALTH LAW PROGRAM, PUBLIC HEALTH LAW ASSOCIATION, PUBLIC HEALTH LAW CENTER AND PUBLIC HEALTH LAW & POLICY AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS REGARDING SEVERABILITY

MARTHA JANE PERKINS
Counsel of Record
COREY S. DAVIS
NATIONAL HEALTH LAW PROGRAM
101 E. Weaver St., # G-7
Carrboro, NC 27510
perkins@healthlaw.org
(919) 968-6308

Counsel for Amici Curiae

SARA ZIMMERMAN
JENNIFER L. WILLIS
PUBLIC HEALTH LAW & POLICY
2201 Broadway, Suite 502
Oakland, CA 94612
(510) 302-3380

Counsel for Amici Curiae

GibsonMoore Appellate Services, LLC • 421 East Franklin Street, Suite 230
Richmond, VA 23219 • 804-249-7770 • www.gibsonmoore.net

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INTEREST OF AMICI CURIAE[1]

The **American Public Health Association** (APHA) is the oldest and most diverse organization of public health professionals in the world. Founded in 1872, APHA represents a broad array of health providers, educators, environmentalists, policy-makers, and health officials working at all levels within and outside government. APHA aims to protect all Americans and their communities from preventable, serious health threats, and strives to ensure that community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States. APHA's goal is for the United States to become the healthiest nation in one generation.

Founded in 1930, the **American Academy of Pediatrics** (AAP) is a national, not-for-profit organization dedicated to furthering the interests of children's health. Since AAP's inception, its membership has grown from 60 pediatricians to over 62,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Over the past 80 years, AAP has become a powerful voice for children's health through education, research, advocacy, and the provision of expert advice.

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[1] The parties have filed notices with the Clerk consenting to the filing of amicus briefs in this case. No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money to fund preparation or submission of this brief. No person, other than *amici* and *amici*'s counsel, made a monetary contribution for the preparation or submission of this brief.

The **American Lung Association** is one of the nation's oldest voluntary health organizations, with more than 400,000 volunteers representing all 50 states and the District of Columbia, Puerto Rico, and the Virgin Islands. Lung disease is the third-leading cause of death in the United States, and is largely preventable. Because cigarette smoking is the leading cause of preventable death and disease in the world, claiming about 443,000 American lives each year, and is a major cause of lung cancer and chronic obstructive pulmonary disease (COPD), the American Lung Association has long been active in research, education, and public policy advocacy regarding the adverse health effects caused by tobacco use and exposure to secondhand smoke.

The **American School Health Association** (ASHA), founded in 1926, supports the terms of Title IV that modernize public health systems, increase access to clinical preventive services, spur the creation of healthier communities and schools, and support key innovations to improve public health under the provisions for the Public Health and the Prevention Fund. ASHA strongly supports the continuation of the Public Health Council in order to turn the nation's focus from sickness and disease to wellness and prevention. ASHA expresses its strong support for the ACA provision providing for the Prevention and Public Health Fund to expand and maintain national investment in prevention. ASHA's members and leadership also commend the Community Transformation Grants to community-based community preventive activities and the health grants for highly effective School Based Health Centers.

Established in 1953, the **Association of Schools of Public Health** (ASPH) represents the forty nine Council on Education for Public Health -accredited Schools of Public Health. In 2011, over 26,000 students were enrolled in graduate level degree programs at ASPH schools, and more than 200,000 current public health workers, principally those employed in the public sector, received short term professional training through programs centered at these schools. In addition to their education and training missions, schools of public health carry out cutting edge research to support the most effective approaches to improving the health of the public. This includes almost $800 million annually of National Institutes of Health sponsored research as well as substantial work for the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the U.S. Agency for International Development, and many other federal agencies.

The **National Association of County and City Health Officials** (NACCHO), a non-profit organization, envisions health, equity, and well-being for all people in their communities through public health policies and services. As a leader, partner, catalyst, and voice for the nation's 2800 local health departments, NACCHO provides education, information, research, and technical assistance and facilitates partnerships among local, state, and federal agencies to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives.

The **National Association of Local Boards of Health** (NALBOH) informs, guides, and is the national voice for boards of health. Uniquely positioned to deliver technical expertise in governance and leadership, board development, health priorities, and public health policy, NALBOH strives to strengthen good governance where public health begins—at the local level. The Affordable Care Act's prevention and public health provisions are important to NALBOH because they empower boards of health and local communities with vital resources and tools to ensure they can provide the programs, services, and policies necessary to prevent disease and promote health initiatives that result in healthier communities.

The **National Health Law Program** (NHeLP) is a 40-year-old public interest law firm that works to advance access to quality health care, improve the public's health, and protect the legal rights of lower-income people and people with disabilities. NHeLP engages in education, policy analysis, administrative advocacy, and litigation.

The **Public Health Law Association** (PHLA) was formed in 2003 as a non-profit membership organization. It serves as an independent voice for public health attorneys and other stakeholders who shape, use, teach, study, or conduct research in the highly dynamic field of public health law and policy. PHLA is dedicated to using public health law to promote healthy people and healthy communities through dialogue, partnerships, education, and research.

The **Public Health Law Center** (the Center) is a non-profit public interest legal resource center at the William Mitchell College of Law in Saint Paul, Minnesota. The Center helps local, state, and national leaders improve public health by strengthening law. The Center frequently prepares amicus briefs in support of public policies that benefit the nation's health.

Public Health Law & Policy (PHLP) is a national nonprofit, composed of attorneys, policy analysts, and urban planners dedicated to building healthy communities nationwide. PHLP develops legal and policy tools to create lasting change, working with advocates, public officials, and others who want to improve public health conditions where they live and work. PHLP engages in policy research and analysis, technical legal assistance, and community-tailored training.

SUMMARY OF ARGUMENT

For more than two centuries, the federal government has played a key role in creating, funding, and improving public health infrastructure and services. The Patient Protection and Affordable Care Act ("the ACA") expands the country's prevention and public health efforts through provisions intended to modernize public health systems, prevent chronic disease, increase access to preventive services, and spur the creation of healthier communities. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). Many of these provisions are already in effect, helping to improve the health of millions of Americans.

The briefs of the United States and supporting *amici* discuss the issue of severability in detail. *Amici* public health and prevention organizations write here to emphasize the crucial importance of federal public health and prevention initiatives not only for the well-being of millions of individuals but also for the United States itself. *Amici* provide the Court with a brief history of federal involvement in public health, an explanation of the importance of prevention and public health initiatives to the health, welfare and security of the country, and a detailed description of the key prevention and public health provisions contained in the ACA.

Given the federal government's longstanding commitment to improving and protecting public health, the ever-growing importance of public health and prevention for the health and security of the nation, and the stand-alone nature of these provisions, this Court should find for the government on the question of severability, should that question be reached.

ARGUMENT

For over two hundred years, federal public health and prevention initiatives have provided extraordinary benefits to the United States and its people. Having tamed and conquered many of the infectious diseases that ravaged human populations for millennia, Americans can now expect that their children will survive to adulthood and that they will live to old age. But new and renewed threats make public health and prevention as crucial now as they were in previous centuries. Epidemic levels of chronic disease threaten to shorten the average lifespan. Emerging threats such as drug-resistant contagions and bioterrorism require new techniques, tactics, and training. Therefore, the role of the federal government in directing and coordinating public health preparedness, research, and response is more important than ever.

Amici urge this Court to find for respondents on the question of severability, should that question be reached. As noted by the federal government and other amici, the ACA contains "hundreds of . . . provisions" that have a "manifest lack of connection to the individual mandate." *Florida v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1323 (11th Cir. 2011). The initiatives described in this brief are among those provisions and, as discussed below, have a direct, significant, and positive impact on prevention and public health.

I. THE UNITED STATES HAS LONG ACTED TO PROTECT AND IMPROVE THE PUBLIC'S HEALTH

The federal government, in recognition of the fact that public health is a key component of a healthy population, productive workforce, and strong national defense, has long played an active role in providing essential public health infrastructure and services. This role has evolved over time, as agencies initially launched to address the health of merchant mariners and to support national security during wartime, are now invaluable tools in improving the health of the entire population. Effectively addressing the emerging threats posed by global pandemics, bioterrorism, and preventable chronic illnesses like obesity, diabetes, heart disease, lung disease, and cancer is crucial not only to Americans' physical health, but to the country's economic competitiveness, financial health, and national security as well.

A. The Federal Government has Supported Public Health Since the Dawn of the Nation

The Public Health Service celebrated its bicentennial in 1998, commemorating 200 years of federal public health promotion. Margaret Kaiser, U.S. Dep't of Health & Human Servs., *The United States Public Health Service: An Historical Bibliography of Selected Sources* 1 (1998). Now a division of the Department of Health and Human Services (HHS), the Public Health Service began as a network of hospitals that became known as the Marine Hospital Service (MHS). Alejandro de Quesada, *The U.S. Home Front 1941-45*, at 27 (2008). This network was established in 1798 when Congress, recognizing that a strong merchant marine force was necessary for international commerce and to supplement the Navy in case of war, authorized the creation of a government-operated hospital service for merchant seamen. An Act for the Relief of Sick and Disabled Seamen, 1 Stat. 605 (1798), *available at* http://history.nih.gov/research/downloads/1StatL605.pdf; *see also* Ralph C. Williams, *The United States Public Health Service, 1789-1950*, at 25 (1951). Over time, the MHS's reach was extended to members of the Navy and Coast Guard, as well as certain veterans and dependents. Williams, *supra*, at 47-51.

Responding to the rising threat of contagious epidemics, including a yellow fever epidemic in 1877 that killed an estimated 100,000 to 150,000 Americans, the federal government expanded the MHS's focus to include infectious disease control and surveillance. K. David Patterson, *Yellow Fever Epidemics and Mortality in the United States, 1693-1905*, 34 Soc. Sci. Med. 855, 859 (1992); *see also* Williams, *supra*, at 113-175. In 1878, Congress furthered this effort by passing the first national quarantine act, which banned infected people, merchandise, and animals from entering the country, and tasked the MHS with enforcement. An Act to Prevent the Introduction of Contagious or Infectious Diseases into the United States, 20 Stat. 37 (1878), *available at* http://history.nih.gov/research/downloads/20StatL37.pdf. To assist in surveillance and quarantine efforts, the federal government created programs to track the spread of cholera, smallpox, plague, and yellow fever. Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900-1999: Changes in the Public Health System,* 48 Morbidity & Mortality Wkly. Rep. 1141, 1143 (1999). To reflect this expanded role, in 1912 Congress officially changed the name of the Marine Hospital Service to the Public Health Service. An Act to Change the Name of the Public Health and Marine-Hospital Service to the Public Health Service, to Increase the Pay of Officers of Said Service, and for Other Purposes, 37 Stat. 309 (1912).

B. Federal Public Health Efforts Expanded in the Wartime and Post-War Eras

In recognition of the importance of public health in a time of increasing international instability, in 1939 President Franklin D. Roosevelt placed the Public Health Service under the newly created Federal Security Agency, which was established to promote social and economic security, educational opportunity, and the health of American citizens. Reorganization Plan No. 1 of 1939, 5 U.S.C. App. 1 (1939). During World War II, the Public Health Service grew from 8,000 personnel in 1940 to over 16,000 by 1945 as it expanded to assist injured and disabled soldiers and address growing public health needs at home. de Quesada, *supra*, at 28.

Post-war, federal public health efforts increasingly focused on improving the nation's overall health. The Communicable Disease Center, forerunner of the Centers for Disease Control and Prevention, was created in 1946. Ctrs. for Disease Control & Prevention, *supra*, at 1143. In 1953, the national importance of public health was recognized by the creation of the cabinet-level Department of Health, Education and Welfare. Reorganization Plan No. 1 of 1953, 5 U.S.C. App. 1 (1953). In the 1960s and 1970s, efforts led by the Public Health Service resulted in the worldwide eradication of smallpox, which killed approximately 300 million people in the 20th century alone. Michael B.A. Oldstone, *Viruses, Plagues, and History: Past, Present and Future* 4 (1998); Michelle A. Green & Mary Bowie, *Essentials of Health Information Management* 6 (2005).

In recent years, the federal government has played an active role in protecting and improving public health through measures such as the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, 42 U.S.C. § 300ff (1990), the Vaccines for Children Program, 42 U.S.C. § 1396s (1993), and the Office of Public Health Emergency Preparedness, which coordinates efforts against bioterrorism and other emergency health threats, 42 U.S.C. § 300hh (2006). As discussed in Section II, these and other federal public health initiatives are actively addressing today's major public health threats.

II. PREVENTION AND PUBLIC HEALTH INITIATIVES PROVIDE WIDE-RANGING BENEFITS TO THE UNITED STATES

Public health can be described as an organized effort to prevent disease, prolong life, and promote health. *See* Derek Wanless, *Securing Good Health for the Whole Population* 3 (2004). Essential aspects of public health include monitoring community health status, investigating and diagnosing health problems and hazards, informing and educating the public about health issues, and researching and applying innovative solutions to public health problems. U.S. Dep't of Health & Human Servs., Public Health Functions Steering Committee, *Public Health In America* (1994).

The federal government is uniquely able to protect the American public from threats to public health by coordinating different branches and levels of government, and facilitating communication and response between them and those in need. For example, federal action is necessary to ensure a coordinated response to infectious disease outbreaks that cross state or national borders. Likewise, only the federal government can effectively mount the coordinated response demanded by national-scale health crises, such as the recent dramatic increase in preventable chronic disease.

A. Public Health and Prevention Initiatives are Highly Effective in Improving Length and Quality of Life

Public health efforts have been tremendously successful in improving Americans' length and quality of life:

> Public health's most dramatic accomplishment is the extension of the average life span, from 45 years at the turn of the twentieth century to nearly 80 years in 2002. Of these 35 years of "extra" longevity, only 5 or so can be attributed to advances in clinical medicine. Public health can take the credit for the other 30 years, thanks to improvements in sanitation, health education, the development of effective vaccines, and other advances.

Lawrence Gostin, et al., *The Law and the Public's Health: The Foundations*, in *Law in Public Health Practice* 3, 6 (Richard A. Goodman et al. eds., 1st ed. 2003).

Public health and prevention initiatives have resulted in marked successes in such disparate areas as survival of infants and mothers, safety of food and water, control of deadly infectious diseases, and prevention of tobacco-related illness. *See* Ctrs. for Disease Control & Prevention, *Ten Great Public Health Achievements-United States, 1900-1999*, 48 Morbidity & Mortality Wkly. Rep., 241, 242-43

(1999). Infections such as typhoid and cholera, which were a major cause of illness and death early in the 20th century, are almost unheard of today. *Id.* at 242. Sustained public health efforts have lead to the development and deployment of vaccines for a host of deadly ailments including measles, rubella, mumps, and rabies. Stanley A. Plotkin, *History of Vaccine Development* 3 (Stanley A. Plotkin ed., 2011). Polio, one of the most dreaded childhood diseases of the first half of the 20th century, has been nearly eradicated. David M. Oshinsky, *Polio: An American Story* 271, 273 (2005). Indeed, due in large part to public health and prevention activities, the age-adjusted death rate in the United States has reached a record low. *See* Ram Koppaka, Ctrs. for Disease Control & Prevention, *Ten Great Public Health Achievements-United States, 2001- 2010*, 60 Morbidity & Mortality Wkly. Rep. 619, 621 (2011).

Studies increasingly confirm the old adage that an ounce of prevention is worth a pound of cure. Strong and abundant evidence demonstrates that preventing illness, particularly chronic illness, is often more cost-effective than caring for individuals once they become ill. *See* Robert Wood Johnson Foundation, *Return on Investment in Public Health: A Summary of Groundbreaking Research Studies* (2011), http://www.rwjf.org/files/research/72990.prevention.brief.pdf. Immunizations, for example, are one of the most effective medical and public health interventions ever created. *See,* Sandra W. Roush et al., *Historical Comparisons of Morbidity and Mortality for Vaccine-Preventable Diseases in the United States*, 298 JAMA 2155, 2160 (2007). Likewise, for every HIV infection prevented, an estimated $355,000 is saved in the cost of providing lifetime HIV treatment. Bruce Schackman et al., *The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States*, 44 Med. Care 994 (2006).

Turning to chronic disease, estimates show that reducing diabetes and hypertension prevalence by five percent would save the United States approximately $9 billion annually. Barbara A. Ormond et al., *Potential National and State Medical Care Savings from Primary Disease Prevention*, 101 Am. J. Public Health 160, 165 (2011). Similarly, increasing preventative actions such as childhood immunization, discussion of daily aspirin use, smoking cessation assistance and vision screening from current levels to 90% utilization could save $3.7 billion annually in medical costs. Michael V. Maciosek, *Greater Use of Preventive Services in U.S. Health Care Could Save Lives At Little Or No Cost*, 29 Health Affairs 1656, 1658 (2010).

B. Public Health and Prevention Programs are More Important Now than Ever

1. Chronic disease is a large and growing threat

Chronic diseases remain the country's most frequent cause of sickness and death, killing seven out of every ten Americans. *See* Arialdi M. Miniño et al., Nat'l Ctr. for Health Stats., *Deaths: Final Data for 2008*, 59 Nat'l Vital Stat. Rep. 17 (2011). Every year, nearly 800,000 Americans have a first heart attack, and another 470,000 have a repeat heart attack. Donald Lloyd-Jones, et al. *Heart Disease and Stroke Statistics–2011 Update*. 123 Circulation e1, e2 (2011). Cardiovascular disease is responsible for one out of every four U.S. deaths - roughly 600,000 Americans per year. Miniño, *supra*, at 17. Cancer, the second leading cause of death in the United States, afflicts 1.6 million Americans and claims more than half a million lives every year. *Id.*; American Cancer Society, *Cancer Facts and Figures 2011*, at 1 (2011), http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-029771.pdf. Lung disease is now the third leading cause of death in America. Miniño at 17. Approximately 90% of chronic respiratory disease is caused by tobacco smoking and is therefore almost completely preventable. U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *The Health Consequences of Smoking: A Report of the Surgeon General* 464 (2004). The recent outbreaks of H1N1, H5N1 and SARS remind us that communicable disease is an ever-present threat; indeed, influenza and pneumonia kill over 50,000 Americans each year. Miniño, *supra*, at 17.

The chronic diseases of obesity, diabetes, and lung disease are responsible for debilitating health problems in increasing numbers of Americans. In 2010, 60% of Americans were overweight or obese, with 18% of 12-19 year olds meeting the criteria for obesity. Cynthia L. Ogden & Margaret Carroll, Ctrs. for Disease Control & Prevention, *Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults: United States, Trends 1960–1962 Through 2007–2008*, at 1 (2010), http://www.cdc.gov/nchs/data/hestat/obesity_adult_07_08/obesity_adult_07_08.pdf. Diabetes, which often results from obesity, is the leading cause of kidney failure and blindness among adults aged 20-74 and a major contributing factor to heart disease and stroke. Ctrs.

for Disease Control & Prevention, *National Diabetes Fact Sheet: National Estimates and General Information on Diabetes and Prediabetes in the United States* 1 (2011). Nearly 26 million people now have diabetes – more than 8% of the American population – and 79 million (35% of U.S. adults) over age 20 have pre-diabetes. *Id.* More than 35 million Americans have chronic lung diseases. American Lung Association, *Lung Disease Data 2008*, at 7 (2008), http://www.lungusa.org/assets/documents/publications/lung-disease-data/LDD_2008.pdf.

2. Poor health generates enormous economic costs and threatens national security

The poor health status of the American people is extremely costly in terms of direct expenditures. On average, annual health care costs are $2,000 higher for smokers, $1,400 higher for obese individuals, and $6,600 higher for people with diabetes than for those without these conditions. Leif I. Solberg et al., *Repeated Tobacco-Use Screening and Intervention in Clinical Practice: Health Impact and Cost Effectiveness*, 31 Am. J. Prev. Med. 62, 65 (2006); Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer and Service-Specific Estimates*, 28 Health Affairs 822, 826 (July 2009); Tim Dall et al., *Economic Costs of Diabetes in the U.S. in 2007*, 31 Diabetes Care 596, 608 (2008). One of every five U.S. health care dollars is spent on caring for people with diabetes. Dall, et al., *supra*, at 596. If current trends continue, 65 million more adults will be obese in 2030 than today, leading to six million more Americans suffering from diabetes, five million from coronary heart disease and stroke, and more than 400,000 more suffering from cancer than would be expected at current rates, at an increased cost of between 48 and 66 billion dollars per year. Y. Claire Wang et al., *Health and Economic Burden of the Projected Obesity Trends in the USA and the UK*, 378 The Lancet 815, 823 (2011).

Cardiovascular disease now accounts for nearly 20% of medical expenditures and 30% of Medicare expenditures. Justin G. Trogdon et al., *The Economic Burden of Chronic Cardiovascular Disease for Major Insurers*, 8 Health Promotion Practice 234, 239 (2007). Meanwhile, the national annual health care cost of treating obesity-related diseases in adults is approximately $147 billion. Finkelstein et al., *supra*, at 826. The cost of obesity is compounded when combined with other illnesses and diseases: obesity increases lifetime medical care costs for some diseases by 50%, and severe obesity can almost double these costs. Ross A. Hammond & Ruth Levine, *The Economic Impact of Obesity in the United States*, 3 Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy 285, 287 (2010). Lung disease costs the U.S. economy a total of $173 billion per year, including $108 billion in direct health care expenditures. Nat'l Inst. of Health, *Morbidity & Mortality: 2009 Chart Book on Cardiovascular, Lung and Blood Diseases* 17 (2009), http://www.nhlbi.nih.gov/resources/docs/2009_Chart Book.pdf.

Poor health costs individuals, companies, and the country in numerous additional ways as well. Chronic diseases and other health conditions reduce economic output by $260 billion per year. Rebecca Mitchell & Paul Bates, *Measuring Health-Related*

Productivity Loss, 14 Population Health Mgmt. 93(2011). Indirect costs from poor employee health including lower productivity, higher rates of disability, higher rates of injury, and more workers' compensation claims can be two to three times the costs of direct medical expenses. Partnership for Prevention and U.S. Chamber of Commerce, *Leading by Example: Leading Practices for Employee Health Management* 6 (2007). Poor oral health is significantly associated with disability and reduction in mobility. Institute of Medicine of the National Academies and National Research Council, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations* 2-9 (2011).

Preventable disease also directly and negatively affects our national security. Between 1995 and 2008, 140,000 military recruits failed their physical entrance exams because they were overweight. Mission: Readiness, *Too Fat to Fight: Retired Military Leaders Want Junk Food Out of America's Schools* 2 (2010), http://cdn.missionreadiness.org/MR_Too_Fat_to_Fight-1.pdf. Alarmed that the epidemic of obesity threatens our national security, dozens of retired generals, admirals, and other senior leaders of the U.S. Armed Forces have issued a call to action to improve fitness and reduce unhealthy eating. *Id.* Chronic diseases such as obesity negatively affect our national security in other ways as well: passenger weight gain between 1960 and 2002 has required the use of almost one billion additional gallons of gasoline per year, further deepening our dependence on fossil fuels. Sheldon H. Jacobson & Laura McLay, *The Economic Impact of Obesity on Automobile Fuel Consumption*, 51 Engineering Economist 307, 320 (2006).

III. THE AFFORDABLE CARE ACT STRENGTHENS AND PRIORITIZES PUBLIC HEALTH AND PREVENTION

As we move into the twenty-first century, public health and prevention agencies are evolving to meet the challenges posed by emerging threats such as chronic debilitating conditions, pandemic flu and other infectious disease, and natural and man-made disasters. Koppaka, *supra*, at 60. In response to these new challenges, the ACA strategically provides resources, builds expertise, and creates frameworks for quickly and effectively addressing current and emerging threats to Americans' health and well being.

The ACA is divided into ten titles. The individual mandate and Medicaid expansion challenged in this case are contained in Titles I and II. *Amici* focus here on key provisions contained in Title IV, entitled "Prevention of Chronic Disease and Improving Public Health." Title IV modernizes public health systems, increases access to clinical preventive services, spurs the creation of healthier communities, and supports key innovations to improve public health. ACA §§ 4001-4402.[2]

A. Nationwide Programs Focused on Prevention and Public Health

In Title IV, Congress crafted high-level programs to systematically guide public health research and infrastructure development: a national prevention strategy, federal funding initiatives, and programs focused on specific health conditions. To oversee these activities, the ACA created the National Prevention, Health Promotion and Public Health Council ("Council"), tasked with providing federal coordination and leadership in prevention, wellness, and health promotion. ACA § 4001, 42 U.S.C.A. § 300u–10 (West 2011). Established in 2010, the Council is composed of the heads of seventeen federal agencies and chaired by the Surgeon General. Executive Order 13544, 75 Fed. Reg. 33, 983 (June 10, 2010). With input from the public and interested stakeholders, the Council has developed a National Prevention and Health Promotion Strategy that focuses on shifting from a focus on sickness and disease to one based on wellness and prevention. *See* National Prevention, Health Promotion and Public Health Council, *National Prevention Strategy* 3 (2011), *available at* http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.

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[2] This section also highlights additional prevention provisions found in Title X, the Manager's Amendment, that modify Title IV.

Congress also made a substantial investment in public health by creating a dedicated funding source for national investment in prevention and public health programs. This Prevention and Public Health Fund is designed "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health costs." ACA § 4002, 42 U.S.C.A. § 300u–11 (West 2011). This significant investment, which begins at $500 million per year and increases to $2 billion per year, is intended to radically improve and expand the capacity of public health efforts, saving thousands of lives and potentially improving the health of many millions of Americans. *Id.*

The ACA also authorizes task forces to review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services, and to develop evidence-based recommendations informed by those reviews. ACA § 4003, 42 U.S.C.A. § 280g–10 (West 2011). A focus on determining which interventions are most effective and cost-effective, and selectively encouraging those interventions, is present throughout the ACA, including many provisions that require initiatives funded under their auspices to utilize evidence-based practices. *See, e.g.*, ACA §§ 4105, 10408, 10410.

B. Initiatives Focused on Specific Diseases, Conditions, and Barriers to Health

The ACA systematically takes on a number of America's most persistent and challenging health conditions by creating specific initiatives to address particular diseases. One such provision, a national diabetes prevention program targeted at adults at high risk for diabetes, includes a grant program for community-based model sites, as well as evaluation, monitoring, and technical assistance. ACA § 10501(g). Another provision requires that HHS create and disseminate national diabetes report cards and, to the extent possible, a report card for each state. ACA § 10407, 42 U.S.C.A. § 247b–9a (West 2011). It also requires HHS to study and report on the impact of diabetes on medical care and the appropriateness of medical education regarding the disease. *Id.* The ACA appropriates $25 million each year during the 2010-2014 financial years period for demonstration projects to address the related problem of childhood obesity. ACA § 4306. The ACA also addresses the persistent and preventable problem of poor oral health with a number of measures, including a five year public education campaign, the establishment of cooperative agreements with states, territories and tribal entities to establish programs to improve oral health, and grants for projects that demonstrate the effectiveness of dental disease management. ACA § 4102, 42 U.S.C.A. § 280k–1-3 (West 2011).

As discussed above, immunizations are extremely effective in reducing the incidence of many serious diseases, and continued development is necessary to combat the threat of pandemic contagion. Unfortunately, immunization rates in the United States consistently fall below recommended levels. Ctrs. for Disease Control & Prevention, *2009 Adult Vaccination Coverage* 1 (2010), http://www.cdc.gov/vaccines/stats-surv/nhis/2009-nhis.htm. Title IV addresses this problem with a number of activities designed to make vaccines more available and affordable. It authorizes the Secretary to negotiate and enter into contracts with manufacturers to purchase vaccines for adults and authorizes states to purchase vaccines at those negotiated prices. ACA § 4204. Title IV also requires demonstration programs to improve immunization coverage for adults, adolescents, and children, and requires a study of Medicare beneficiary access to vaccines. *Id.*

The ACA directly addresses, at the federal level, a problem that has been addressed to varying degrees in many states: the challenge faced by breastfeeding women returning to work after giving birth. Despite overwhelming evidence that breastfeeding and the exclusive provision of breast milk to infants improves health and saves money, the percentage of American women who breastfeed remains far below recommendations of medical experts and governmental organizations. *See, e.g.*, Alan S. Ryan et al., *Breastfeeding Continues to Increase Into the New Millennium*, 110 Pediatrics 1103, 1104 (2002); Liesbeth Duijts et al., *Breastfeeding Protects Against Infectious Diseases During Infancy in Industrialized Countries: A Systematic Review*, 5 Maternal and Child Nutrition 199, 199 (2009). The ACA attempts to address this problem by requiring employers to provide an employee covered by the Fair Labor Standards Act with "reasonable break time . . . to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk." ACA § 4207 (amending 29 U.S.C. § 207).

C. Improving Health in Communities, Schools, and Workplaces

Because healthy environments can drive improvements in public health and well-being, Congress included a number of initiatives in Title IV aimed at improving health through place-based approaches. Chief among these initiatives is a program to provide Community Transformation Grants to state and local governments, community-based organizations, and Indian tribes to implement and evaluate evidence-based community preventive activities aimed at reducing rates of chronic disease, addressing health disparities, and developing an evidence base for future prevention programming. ACA § 4201, 42 U.S.C.A. § 300u–13 (West 2011).

The ACA seeks to address children's health through grants for School Based Health Centers. These centers are required to provide comprehensive primary health services during school hours to children and adolescents. Grants will be directed to communities with barriers to primary health care and prevention services and those with high numbers of uninsured and underinsured children. ACA § 4101, 42 U.S.C.A. § 280h–4-5 (West 2011).

Research has shown that medical costs are reduced by approximately $3.27 and absenteeism costs are reduced by approximately $2.73 for every dollar spent on workplace wellness programs. Katherine Baicker et al., *Workplace Wellness Programs Can Generate Savings*, 29 Health Affairs 304, 308 (2009). The ACA supports workplace wellness in several ways. First, it provides for a five-year grant program emphasizing evidence-based research and best practices for small businesses to provide comprehensive workplace wellness programs. ACA § 10408. The ACA also directs the CDC to provide employers with technical assistance, consultation, tools, and other resources to improve their workplace wellness programs. ACA § 4303.

CONCLUSION

Prevention and public health are essential to the health of the American people. Given the federal government's longstanding commitment to improving and protecting public health, the ever-growing importance of public health and prevention for the health and security of the nation, and the stand-alone nature of these provisions, this Court should find for the government on the question of severability, should that question be reached.

Respectfully submitted,

/s/ Martha Jane Perkins
MARTHA JANE PERKINS
Counsel of Record
COREY S. DAVIS
NATIONAL HEALTH LAW PROGRAM
101 E. Weaver St., # G-7
Carrboro, NC 27510
perkins@healthlaw.org
(919) 968-6308

SARA ZIMMERMAN
JENNIFER L. WILLIS
PUBLIC HEALTH LAW & POLICY
2201 Broadway, Suite 502
Oakland, CA 94612
(510) 302-3380

Counsel for Amici Curiae

AMICUS CURIAE BRIEF

Nos. 11-393, 11-398, and 11-400

In The
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DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*,
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ROGER G. WILSON
SENIOR VICE-PRESIDENT & GENERAL COUNSEL
BLUE CROSS BLUE SHIELD ASSOCIATION
225 N. Michigan Ave.
Chicago, IL 60601
(312) 297-6000

JOSEPH MILLER
JULIE SIMON MILLER
AMERICA'S HEALTH INSURANCE PLANS
601 Pennsylvania Avenue, N.W.
South Building, Suite 500
Washington, DC 20004
(202) 778-3200

PATRICIA A. MILLETT
Counsel of Record
ORLY DEGANI
JAMES E. TYSSE
AKIN, GUMP, STRAUSS, HAUER & FELD LLP
1333 New Hampshire Ave N.W.
Washington, DC 20036
(202) 887-4000
pmillett@akingump.com

Counsel for Blue Cross Blue Shield Association

Counsel for America's Health Insurance Plans

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INTEREST OF AMICI CURIAE[1]

America's Health Insurance Plans ("AHIP") is the national trade association that represents companies providing health insurance coverage to more than 200 million Americans. AHIP has over fifty years of experience in the health insurance industry (as AHIP and its predecessors). Its members offer a wide range of insurance options to consumers, employers of all sizes, and governmental purchasers nationwide. As a result, AHIP's members have extensive experience working with hospitals, physicians, pharmaceutical and device companies, and other health care stakeholders to ensure that patients have access to needed treatments and medical services. That gives AHIP extensive first-hand and historical knowledge about the Nation's health care and health insurance systems and a unique understanding of how those systems work.

The Blue Cross and Blue Shield Association ("Blue Cross Blue Shield") is a non-profit association of 38 independent, community-based, and locally operated health insurance companies. Those companies collectively provide healthcare coverage for nearly 99 million people—one out of three Americans—in every zip code in the United States, the District of Columbia, and Puerto Rico. Blue Cross and Blue Shield companies offer a variety of

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[1] All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk. No counsel for a party authored this brief in whole or in part, and no person other than amici made a monetary contribution intended to fund the preparation or submission of this brief.

insurance products to all segments of the population, including federal employees, large employer groups, small businesses, and individuals. As leaders in the healthcare community for more than 80 years, the Blue Cross and Blue Shield companies have a commitment to making healthcare work for all Americans and have an extensive knowledge of and experience with the health insurance marketplace.

Health insurance plans are among the entities most directly and extensively regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA" or "Act"). AHIP and Blue Cross Blue Shield are filing this brief to share with the Court the uniquely comprehensive information that they and their members possess about how the health insurance market operates, the changes that will be made by the Act, and the consequences that would follow from decoupling the Act's minimum individual insurance coverage provision from certain insurance-market reforms.

AHIP and Blue Cross Blue Shield have each previously appeared as amicus curiae before this Court in other cases involving issues of particular importance to the health insurance industry. *See, e.g.*, *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008) (Blue Cross Blue Shield & AHIP; judicial review of benefit determinations by ERISA plan administrators); *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006) (Blue Cross Blue Shield & AHIP; addressing whether an ERISA fiduciary may sue a beneficiary for reimbursement of medical expenses paid by the ERISA plan when the beneficiary has recovered for its injuries from a third party); *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (ERISA preemption of state-law claims against health maintenance organizations) (brief filed by AHIP's predecessor, AAHP-HIAA).

INTRODUCTION

1. This brief does not address the constitutionality of ACA's minimum individual insurance coverage provision, 26 U.S.C. § 5000A (Suppl. IV 2011). Nor does this brief address the Anti-Injunction Act, 28 U.S.C. § 2283 (1948), or Medicaid questions pending before this Court. Instead, this brief focuses exclusively on severability, in the event the Court reaches that question. With respect to that issue, AHIP's and Blue Cross Blue Shield's extensive, first-hand, and on-the-ground experience with health insurance markets, as well as their direct experience with earlier failed state efforts to implement certain insurance-market reforms without a minimum individual coverage mandate, allow them to bring a uniquely informed voice to this Court. The purpose of this brief is to share that perspective with the Court to help guide the proper legal analysis. This brief does not address any other constitutional, procedural, or severability questions that are outside AHIP's and Blue Cross Blue Shield's unique expertise in the health insurance market.

2. On March 30, 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the

Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA" or "Act"). ACA is a voluminous statute with a multitude of interlocking and interdependent provisions. Congress's stated intent was to increase the accessibility and affordability of health insurance and to reduce the frequency with which the cost of care for the uninsured is shifted to those who maintain health insurance. 42 U.S.C. § 18091(2)(B)-(G) (Suppl. IV 2011) (ACA § 1501(a)). While ACA addresses those issues through a variety of provisions, some of the Act's most significant reforms are aimed at the health insurance market.[2]

As most relevant to this brief, ACA's reforms of the insurance market include: (i) a "guaranteed issu[e]" provision that requires insurers to issue health care coverage to any individual who applies for it, 42 U.S.C. § 300gg-1 (PHSA § 2702, as amended by ACA § 1201(3)(A)); (ii) a prohibition on excluding preexisting medical conditions from coverage or imposing a waiting period before their coverage, 42 U.S.C. § 300gg-3 (PHSA § 2704, as added by ACA § 1201(2)(A)); (iii) a prohibition on the establishment of coverage eligibility rules that are based on health-status related factors, 42 U.S.C. § 300gg-4 (PHSA § 2705, as added by ACA § 1201(4)); and (iv) the required use of an adjusted "community rating" system that prevents health plans from setting premium prices based on an individual applicant's medical history and that sharply limits variations in rates based on age, rating areas, or tobacco usage, *see* 42 U.S.C. § 300gg(a)(1) (PHSA § 2701, as added by ACA § 1201(4)). Those four reforms are referred to here collectively as "the insurance-market reforms." Congress packaged them together as a legislative mechanism for ensuring that all individuals have access to health insurance that is based on premium prices that are rated across a community of individuals rather than individual risk factors.[3]

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[2] The reforms relevant here were implemented through amendments and additions to the Public Health Service Act of 1944, 42 U.S.C. §§ 201 *et seq.* ("PHSA").

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[3] Traditionally, health insurance in the United States is sold in three markets: individual consumers, small group, and large group. S. Rep. No. 89, 111th Cong., 1st Sess. 10 (2009). The guaranteed-issue requirement existed in the small group market prior to ACA, and limitations on preexisting condition exclusions and on coverage eligibility rules that discriminated based on health status previously existed in both the large and small group markets. *See* 42 U.S.C. § 300gg (2009) (limiting preexisting condition exclusions in the small and large group markets), amended and transferred to 42 U.S.C. § 300gg-3 by ACA § 1201(2)(A); 42 U.S.C. § 300gg-11 (2009) (guaranteeing issuance of coverage in the small group markets), redesignated as 42 U.S.C. § 300gg-1 by ACA § 1001(3), stricken by ACA § 1562(c)(8) (renumbered as ACA § 1563(c)(8) by ACA § 10107), amended and transferred to 42 U.S.C. § 300gg-1 by ACA § 1201(4); 42 U.S.C. § 300gg-1 (2009) (prohibiting coverage eligibility rules in the group markets based on certain health-status-related factors), stricken by ACA § 1201(3)(A) and transferred by ACA § 1201(3)(B) to end of new 42 U.S.C. § 300gg-4. Similar protections also applied pre-ACA in the individual market, but only to certain individuals exiting prior group coverage who (1) were no longer eligible for group coverage, (2) satisfied specified "creditable coverage" conditions, (3) exhausted all available COBRA and any similar state coverage programs, (4) were not eligible for coverage under any other government program, and (5) were not terminated from the immediately prior coverage based on nonpayment of premiums or fraud. There was no restriction on setting premium rates for such individuals based on health status or

In conjunction with its adoption of those insurance-market reforms, Congress also enacted a provision that requires every person, with limited exceptions, to maintain "minimum essential" health insurance coverage. 26 U.S.C. § 5000A. That provision is sometimes referred to as the "individual mandate."

In ACA, Congress found that, if the guaranteed-issue requirement and the prohibitions on preexisting-condition exclusions and health-status-related eligibility determinations were implemented without the minimum individual coverage mandate, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(2)(I). Congress further found that the individual coverage requirement would help to "minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.* Congress thus concluded that the minimum individual coverage provision is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.*

SUMMARY OF THE ARGUMENT

The central flaw in the Eleventh Circuit's holding that the minimum individual coverage provision is

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age. *See* 42 U.S.C. § 300gg-41(a), (b), (f). Those protections that preexisted ACA are not at issue in this brief.

completely severable from the balance of ACA is that the court largely confined its analysis to the narrow question of whether ACA could structurally be operative or enacted as a law without the minimum individual coverage provision. This Court, however, has held that severability turns on whether the remaining portions of the law "will function in a manner consistent with the intent of Congress" without the minimum individual coverage provision. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (emphasis omitted). Indeed, it is this Court's duty, in executing a judgment of unconstitutionality (should one arise), to undertake a full severability analysis that determines which provisions are so dependent on the mandate that, to leave them in place, would violate congressional intent and would, in effect, judicially create a statute that Congress would not have enacted.

Congress adopted its insurance-market reforms—guaranteed issue, prohibitions on preexisting condition exclusions or waiting periods, ban on coverage eligibility rules based on health-related factors, and the adjusted community rating system—together with the mandate as a package deal. The statutory text and legislative record establish that Congress would not have intended those insurance-market reforms to operate on their own, without the vital counterbalance of the minimum individual coverage mandate there to prevent the skyrocketing premiums that would otherwise arise due to crippling adverse-selection and cost-shifting problems.

Indeed, the Congress that enacted ACA had already seen the failed consequences of state efforts to impose similar guaranteed issue, preexisting condition, health-status discrimination, and adjusted community rating reforms in the insurance market without a minimum individual insurance coverage mandate. Congress knew that, with such reforms, those who are most at risk of incurring substantial health costs pour into the insurance market once coverage is guaranteed and rates and exclusions are uncoupled from their individual health risk. At the same time, healthy individuals largely stay out, preferring to wait and purchase insurance only if and when the need arises.

In the absence of an individual coverage requirement, those reforms would dramatically skew the insurance pool by eliminating the price incentives for young and healthy people to purchase coverage, leading to a higher-cost mix of individuals in the insurance pool. This, in turn, would further increase premium prices, driving still more healthy individuals out of the insurance market. The result would be a "marketwide adverse-selection death spiral" that would thwart rather than advance Congress's goal of expanding affordable health care.[4]

The antidote to such market-crippling adverse-selection and cost-shifting problems, Congress determined, was the imposition of a mandate that all individuals have insurance. In Congress's judgment, the requirement that individuals maintain a base level of health insurance would ensure a workable insurance system with a stable and balanced insurance-risk pool and without the adverse-selection and cost-shifting problems that would otherwise arise if insurance could be easily purchased only when needed. Indeed, Congress expressly found that the minimum individual coverage provision is "essential" to making its insurance-market reforms work. 42 U.S.C. § 18091(2)(I).

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[4] Alan C. Monheit, *et al.*, *Community Rating and Sustainable Individual Health Insurance Markets in N.J.*, 23 Health Affairs 167, 169 (2004).

Congress's express finding of an "essential" link between the minimum individual coverage provision and the insurance-market reforms, combined with Congress's awareness of the States' distressing experiences with mandate-less insurance reforms, together demonstrate that Congress did not intend to implement those reforms without the mandate. Congress instead legislatively calibrated a package of insurance-market reforms that interlocked with the minimum individual coverage mandate to counterbalance the adverse-selection problems and spiraling premiums that such reforms, operating alone, had been shown to cause.

Were the mandate to be invalidated, those interdependent legislative provisions would be torn apart and the "essential" counterbalance stripped away, leaving the insurance-market reforms incapable by themselves of functioning as Congress intended. In fact, without a minimum individual coverage mandate to prevent the congressionally acknowledged adverse-selection and cost-shifting problems, those insurance-market reforms would confound Congress's legislative aims by causing premium prices to rise dramatically, thereby driving insurance products and consumers out of the marketplace. In other words, the insurance-market reforms without the minimum individual coverage provision would be an edifice without a foundation, delivering the opposite of what Congress intended by ensuring that there would not be "affordable care" under the Affordable Care Act.

ARGUMENT

ACA'S INSURANCE-MARKET REFORMS CANNOT FUNCTION AS CONGRESS INTENDED WITHOUT THE MINIMUM INDIVIDUAL COVERAGE PROVISION AND THUS ARE INSEVERABLE FROM THE MANDATE

A. The Critical Severability Inquiry Is Whether Congress Intended ACA's Insurance-Market Reforms To Function Without The Minimum Individual Coverage Provision That Congress Deemed "Essential" To Their Operation

"[A] decision to declare an Act of Congress unconstitutional 'is the gravest and most delicate duty that this Court is called on to perform.'" *Rust v. Sullivan*, 500 U.S. 173, 191 (1991) (quoting *Blodgett v. Holden*, 275 U.S. 142, 148 (1927) (opinion of Holmes, J.)). When, in executing that constitutional duty, the Court determines that only a portion of a statute is unconstitutional, the Court must decide whether to invalidate the statute in its entirety, the unconstitutional provision alone, or the unconstitutional provision and those provisions that

Congress intended to work in inextricable conjunction with the unconstitutional provision.

Because the enactment of legislation is constitutionally confined to the Legislative Branch, basic separation-of-powers principles require that, when implementing a judgment of unconstitutionality, this Court not leave standing a law that would "'circumvent the intent of the legislature,'" *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329-330 (2006), or that Congress "'would not pass * * * independently,'" *Allen v. City of Louisiana*, 103 U.S. 80, 84 (1880).

Accordingly, if "different clauses of an act are so dependent upon each other that it is evident the legislature would not have enacted one of them without the other," *Huntington v. Worthen*, 120 U.S. 97, 102 (1887), then it is this Court's "duty" to strike down those provisions in conjunction with the invalidated provision, just as much as it is the Court's "'duty * * * to maintain the act in so far as it is valid,'" *Regan v. Time, Inc.*, 468 U.S. 641, 652-653 (1984). In either circumstance, severability analysis implements this Court's constitutional judgment in a manner that fully respects the constitutional assignment of legislative power to the Congress and "give[s] effect to what appears to have been the intent of the legislature." *Allen*, 103 U.S. at 84.

This Court's test for determining severability is "well-established" and reflects the Court's duty to implement its constitutional judgment consistent with those separation-of-powers principles: If Congress "'would not have enacted those provisions which are within its power, independently of that which is not,'" then the provisions are inseverable and, if one is invalidated, the dependent provisions must be stricken too. *Alaska Airlines,* 480 U.S. at 684. That inquiry entails more than the abstract question of whether the remaining portions of a statute could operate or be enacted as law, *see id.*, which was the main focus of the court of appeals' analysis, No. 11-398, Pet. App. 172a-186a. Rather, the critical inquiry "is whether the statute," stripped of the unconstitutional provision, would "function in a manner consistent with the intent of Congress." *Alaska Airlines*, 490 U.S. at 685 (emphasis omitted).

"[T]he touchstone" for severability analysis, therefore, "is legislative intent." *Ayotte,* 546 U.S. at 330. That intent, moreover, must be assessed not from the vantage point of Congress's original desire to enact the entire law, but what Congress's view would have been "*in light of [the] holding*" invalidating a portion of the law. *United States v. Booker*, 543 U.S. 220, 265 (2005).

Accordingly, if this Court were to invalidate the minimum individual coverage provision that Congress deemed "essential" to the insurance-market reforms, 42 U.S.C. § 18091(2)(I), the Court will have to determine whether the statute could "function" as Congress would have intended, *Alaska Airlines,* 490 U.S. at 685, "'had it known'" that the mandate's counterbalance would be stricken out of the law, *Denver Area Educ. Telecomms. Consortium, Inc. v. FCC,* 518 U.S. 727, 767 (1996) (plurality opinion); *see Alaska Airlines*, 490 U.S. at 685 (unconstitutional provision cannot be severed if "the statute created in its absence is legislation that Congress would not have enacted").

Furthermore, because ACA is "a highly complex statute" with "interrelated provisions," the Court "cannot assume that Congress, if faced with the statute's invalidity" in "key" respects, would have preferred that those "interrelated provisions," once disunited, continue to operate alone. *Booker*, 543 U.S. at 248. The Court instead must determine whether Congress "link[ed] specifically the operation" of the minimum individual coverage provision and its insurance-market reforms, or whether Congress instead would have intended for the reforms to "stand on their own, independent of" an invalidated mandate. *Alaska Airlines*, 480 U.S. at 688-689.[5]

ACA's text, structure, and legislative record establish that Congress enacted the minimum individual coverage mandate and its insurance-market reforms as a package deal, that those reforms cannot function as Congress intended without the mandate, and that, in fact, the continued operation of those reforms without the mandate would thwart Congress's central purpose of guaranteeing broad access to *affordable* health care.

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[5] While the presence of a severability clause "creates a presumption that Congress did not intend the validity of the statute in question to depend on the validity of the constitutionally offensive provision," the absence of a severability clause in ACA does not create any countervailing presumption. *Alaska Airlines*, 480 U.S. at 686.

B. ACA's Plain Text Establishes That The Minimum Individual Coverage Provision Is "Essential" To And Thus Inseverable From The Guaranteed Issue, Preexisting Conditions, Health-Status Discrimination, And Adjusted Community Rating Reforms

1. The Mandate and the Insurance-Market Reforms Are Textually Linked

ACA's plain text ties the minimum individual coverage provision and the insurance-market reforms tightly together. Congress expressly found that the minimum individual coverage mandate "is *essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold." 42 U.S.C. § 18091(2)(I) (emphasis added). Congress textually extended that same finding to ACA's prohibition on discrimination based on other health-status-related factors. *See Id.* (citing PHSA § 2705's (42 U.S.C. § 300gg-4) prohibition on health-status discrimination).

That congressional judgment that the mandate is "essential" to guarantee the issuance of insurance to all who apply without regard to health condition, 42 U.S.C. § 18091(2)(I), necessarily subsumed the adjusted community rating system reform, 42 U.S.C. § 300gg(a)(1), as well. The adjusted community rating requirement, which prohibits rates from varying based on health status and limits variations based on age, is a mechanism for spreading risk across a broad, demographically diverse insurance pool and enforcing cross-subsidization by which low-risk individuals (generally young and healthy) collectively pay more and high-risk individuals (generally older and sicker) collectively pay less. Such pooling ensures that the highest cost individuals can purchase health insurance at an affordable premium.

That community rating cross-subsidization is indispensable to making the "guaranteed issue" of insurance and the bar on preexisting condition exclusions and eligibility rules based on health status work. Without a balanced risk pool of sick and healthy alike, premiums would skyrocket because only those who needed coverage would purchase it, while the younger and healthier individuals would postpone purchasing insurance until a health crisis arose. Accordingly, Congress's finding that the mandate is "essential to creating effective health insurance markets" in which insurance is "guaranteed issue" without regard to health status, 42 U.S.C. § 18091(2)(I), necessarily also applies to the adjusted community rating requirement and its inherent dependence on the diverse insurance pool created by the individual coverage mandate.[6]

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[6] Of course, the affordability of health insurance, even with a mandate, is subject to additional factors such as the nature of the benefit package required and the rising cost of care. The point here is that, without community rather than individual-condition based ratings, Congress's effort to make affordable health insurance universally available would have stopped at the starting gate.

Congress's express statutory judgment in Section 18091(2)(I) thus provides the specific legislative linkage that makes the insurance-market reforms—guaranteed issue, preexisting condition prohibitions, health-status discrimination, and adjusted community rating—"'so mutually connected with and dependent on'" the minimum individual coverage provisions "'as to warrant a belief that the legislature intended them as a whole,'" and "if all could not be carried into effect, the legislature would not pass the residue independently[.]" *Allen*, 103 U.S. at 84. When Congress enacts a statutory scheme designed to be "upheld by two legs at once," that itself "suggests the improbability that Congress would have assented to a code supported by only one." *Carter v. Carter Coal Co.*, 298 U.S. 238, 314 (1936). Such "manifest" expressions of statutory "interdependence" by Congress require joint treatment in severability analysis. *Id.* at 315; *see also Booker*, 543 U.S. at 260 ("critical cross-references" between two provisions of a statute requires that both provisions be stricken from the statute).[7]

This case, in fact, is the flipside of *Tilton v. Richardson*, 403 U.S. 672 (1971), in which this Court held that an invalidated provision was fully severable because "nothing in the statute or its objectives intimat[ed] that Congress considered" the unconstitutional provision to be "essential" to the statutory program, *id.* at 684. Congress, of course, not only intimated, but actually found precisely the opposite here, determining that the mandate is "essential" to the intended operation of the guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating reforms in the insurance market. *Cf. Alaska Airlines*, 480 U.S. at 688 (finding full severability where "Congress did not link specifically the operation" of two statutory provisions).

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[7] *Carter* was decided at a time when this Court generally applied a presumption of inseverability, 298 U.S. at 312, which this Court has since rejected, *see Alaska Airlines*, 480 U.S. at 686. Because the law at issue in *Carter* contained a severability clause, however, that case was decided under a presumption "of separability," which could be overcome only by "'the clear probability that the invalid part being eliminated the Legislature would not have been satisfied with what remains,'" *Carter*, 298 U.S. at 312, and thus the analysis fully comported with current severability analysis.

2. Congress's Linkage Accords with the Legislature's Knowledge of Marketplace Realities

Congress's decision to textually weave the mandate and its insurance-market reforms together reflects its knowledge and understanding of the practical interconnection of those measures in creating a viable market for universal insurance.

The insurance market is particularly susceptible to the economic phenomenon of "adverse selection" and its companion problem of cost shifting.[8] Adverse selection occurs because individuals with higher anticipated health care costs—generally less healthy and older individuals—are more likely than healthy and younger people to enter an insurance market.

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[8] *See* Kathryn Linehan, *Underwriting in the Non-Group Health Insurance Market: The Fundamentals* 4 (June 4, 2009).

Health insurance is particularly prone to adverse selection because individuals know more about their own health than insurers do, creating incentives for people at low risk of significant health care needs and expenses to postpone purchasing coverage until they suffer from an illness or expect to need medical treatment.

Such adverse selection significantly increases the costs for all participants in the insurance market. Because insurers generally set premiums according to the expected medical costs of those participating in a coverage pool, premiums increase for all participants when individuals with higher expected health care costs dominate the pool. *See* Linda Blumberg & John Holahan, *Do Individual Mandates Matter? Timely Analysis of Immediate Health Policy Issues* 2 (Jan. 2008). Moreover, it takes little disproportionality in the insurance pool to shift health care costs dramatically. Estimates are that just 5% of the population accounts for almost 50% of all health care costs, and the top 1% accounts for 20% of all health costs. At the same time, half of the population accounts for just 3% of health care spending. *See* Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, Research in Action, Issue 19, Agency for Healthcare Research and Quality, Publication No. 06-0060 (June 2006).[9]

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[9] *See also* Kaiser Family Foundation, *Health Care Costs: A Primer*, at 5 (Mar. 2009); National Inst. for Health Care Mgmt., *Understanding U.S. Health Care Spending*, at 1, 4 (NIHCM Foundation Data Brief July 2011).

The resulting increased cost of insurance makes it even more unlikely that healthy people will purchase coverage. Indeed, up to 20% of uninsured individuals have the financial means to obtain coverage but forgo it, relying instead on emergency care when they need medical treatment. *See* Lucien Wulsin, Jr. & Adam Dougherty, *Individual Mandate: A Background Report* 3-4 (Apr. 2009). When those "free riders," *id.* at 4, require medical care, hospitals and other providers charge those who do have coverage higher prices to compensate for lost costs. Those higher prices, in turn, translate into increased health insurance premiums. Those with insurance are ultimately hit with a "hidden tax" estimated at $368 annually for a single person and over $1,017 for a family to pay for that uncompensated care. Families USA, *Hidden Health Tax: Americans Pay a Premium*, at 6-7 (May 2009) (citing 2008 analysis of private actuarial consulting firm); *see also* Wulsin, Jr. & Dougherty, *supra*, at 3-4 (hidden tax ranges from two to ten percent of private premiums).[10]

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[10] Adverse selection and the resultant cost shifting are of particular concern in the individual market because employers do not subsidize the cost of coverage, as they typically do in the large and small group markets. The group markets are composed of employees formed for purposes other than obtaining insurance, and the subsidy offered by employers results in high participation rates, including by healthy workers, such that the demographic and health status mix in a given pool tends to track the workforce as a whole. But in the individual market, where insureds pay the full premium with no employer subsidy, consumers are naturally more price-sensitive and more likely to wait to purchase insurance until they expect to need medical care. *See* AHIP, *Small Group Health Insurance in 2008:*

Prior to ACA, insurance companies were able to combat those problems of adverse selection and cost shifting by employing the actuarial mechanism of underwriting to set premium rates. That process allowed them to manage risk and hold down costs for their existing enrollees by assessing each applicant's health and age and then making an actuarial judgment about the amount and types of medical services that he or she would likely need. Based on that determination, the insurer might exclude coverage for an applicant's known preexisting conditions, impose a waiting period for coverage (which can prevent the belated or selectively timed purchase of insurance), adjust the applicant's premium to account for the risk, or deny coverage altogether. *See* Linehan, *supra*, at 4-6. By regulating risk, those underwriting practices also allowed insurers to offer lower premiums to younger and healthier people, thereby reducing the disincentives to purchasing insurance and attracting them into the insurance pool. *Id.*

ACA's insurance-market reform provisions eliminate many of those risk-management tools. For example, the guaranteed issue provision requires insurers to issue health care coverage to all individuals who are able to pay the premium. 42 U.S.C. § 300gg–1. The adjusted community rating system prohibits insurers from pricing policies according to an applicant's health status and sharply limits age-based variations. 42 U.S.C. § 300gg. In

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A Comprehensive Survey of Premiums, Product Choices, and Benefits 4 (Mar. 2009).

addition, insurers will no longer be permitted to exclude preexisting conditions from coverage, 42 U.S.C. § 300gg–3, or to base coverage eligibility on an applicant's health status, medical condition, or related factors, 42 U.S.C. § 300gg–4.

The effect of those reforms is to alter fundamentally the insurance business and, in particular, the mechanisms employed for spreading risk and keeping premiums affordable. First, prohibiting reliance on the traditional tools of underwriting would make participation in the insurance market more attractive for older and less healthy individuals with higher expected health care costs, thereby increasing the pressure on premiums, which in turn renders the insurance market less attractive for younger and healthier persons who have lower expected costs and are highly price sensitive. The attraction of a disproportionate share of high-risk individuals into the insurance pool will raise average costs, resulting in higher premiums for everyone. That deep imbalance in the pool of insurance customers can create a "marketwide adverse-selection death spiral" in the individual insurance market. Monheit, *supra*, at 169.

Second and relatedly, Congress recognized that, were the insurance-market reforms to be implemented without the mandate, healthy and younger individuals would have every incentive to take a "wait-and-see" approach, postponing the "purchase [of] health insurance until they needed care," 42 U.S.C. § 18091(2)(I)—the equivalent of "'insuring the building already on fire,'" *Federal Ins. Co. v. Raytheon Co.*, 426 F.3d 491, 499 (1st Cir. 2005).

Since health plans could neither exclude applicants from coverage based on preexisting conditions or other health-related factors, nor increase premiums based on health status, it would often be an entirely rational economic decision for healthy and low-risk individuals to forgo obtaining insurance coverage until their medical circumstances changed.

At the same time, guaranteed issue and community rating provide every incentive for the most unhealthy or medically risky individuals to flood the market because initial premiums could not be increased to reflect their individual medical risk. As a result, the insurance pool would skew dramatically toward individuals with higher health care costs, in turn driving up the cost of insurance—the polar opposite of Congress's intent in enacting the "Affordable" Care Act. *See* Uwe E., *The Case for Mandating Health Insurance*, N.Y. Times (Oct. 23, 2009, 7:06 AM), http://economix.blogs.nytimes.com/2009/10/23/the-case-for-mandating-health-insurance/.

Congress enacted the minimum individual coverage mandate as an antidote to those otherwise economically crippling adverse-selection and cost-shifting problems. *See* 42 U.S.C. § 18091(2)(I). Congress specifically found that, "[b]y significantly increasing health insurance coverage," the mandate requirement would help to "minimize * * * adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.*; *see* S. Rep. No. 89, 111th Cong., 1st Sess. 5 (2009) ("To ensure the insurance market reforms function properly, the [Act] would create a personal responsibility requirement for health care coverage[.]").[11]

Congress also was informed that "guaranteed issue, community rating, and limits on pre-existing condition exclusions and waiting periods *will only be successful if there is an individual mandate to balance the risk in the insured population.*" *Covering the Uninsured: Making Health Insurance Markets Work: Hearing Before the S. Committee on Finance*, 110th Cong., 2d. Sess. 3 (2008) (statement of Pam McEwan, Executive Vice President, Public Affairs and Governance, Grp. Health Coop.) (emphasis added); *see also* Congressional Budget Office, Key Issues in Analyzing Major Health Insurance Proposals, Ch. 2, at 27 (Dec. 2008) (noting that "mandate[s] would increase insurance coverage by making it more costly for individuals to be uninsured and for employers not to offer coverage to their employees").

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[11] The court of appeals described the mandate as "toothless" and thus entirely severable because the amount of the penalty is relatively low and the statute limits enforcement of the penalty provision. No. 11-398, Pet. App. 151a-152a, 183a. However, this Court's operating "presumption of law [is] that * * * citizens obey the law," not that they disregard it in the absence of draconian penalties. *United States v. Norton*, 97 U.S. 164, 168 (1877). In any event, the strength of the penalty needed to enforce mandated behavior in any statute is a quintessentially legislative policy judgment. It has no bearing on the separate legal question of whether Congress, had it known that the mandate would be invalidated, would have wanted the insurance-market reforms to stand on their own, without *any* statutory mechanism (of any strength) for countering the known adverse-selection and cost-shifting problems.

Finally, the vital interconnectedness of the minimum individual coverage mandate and the insurance-market reforms was reconfirmed by the Congressional Budget Office, which advised shortly after the law's passage that, implementation of those market reforms without the minimum individual coverage provision would increase premiums for new policies by approximately 15% to 20% because of the adverse-selection problem that would result. *See* Congressional Budget Office, Effects of Eliminating the Individual Mandate to Obtain Health Insurance at 2 (June 16, 2010). About 16 million additional people would remain uninsured in 2019 (39 million rather than 23 million) without the mandate, according to that report. *Id.*[12]

Those reasons are why Congress determined that the minimum individual coverage mandate "is *essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(2)(I) (emphasis added). Given the known economically and programmatically damaging consequences of guaranteeing the issuance of insurance without regard to individual health status or the timing of the insurance application,

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[12] Because of adverse selection, that missing 16 million individuals is likely to include healthier and younger individuals, underscoring that a system of market reforms unaccompanied by an individual mandate would create widespread and potentially economically disabling instability in the insurance market. Over time, that would substantially reduce access to affordable coverage, the opposite of what Congress sought to achieve by enacting ACA.

Congress would not have wanted its insurance-market reforms to "stand on their own," *Alaska*, 480 U.S. at 689, without the mandate present to temper the severe adverse-selection and cost-shifting problems. Quite the opposite, ACA's text documents that Congress considered the minimum individual coverage provision and its insurance-market reforms "not like a collection of bricks, some of which may be taken away without disturbing the others, but rather * * * like the interwoven threads constituting the warp and woof of a fabric, one set of which cannot be removed without fatal consequences to the whole." *Carter*, 298 U.S. at 315-316.

C. Congress Knew That States' Efforts To Implement Similar Market Reforms Without A Mandate Had Not Worked

1. Congress Was Aware of Failed State Reform Efforts

To determine whether a law can "function in a manner consistent with * * * the original legislative bargain," this Court considers not only the text and structure of the law, but also the experiential backdrop against which Congress legislated. *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted); *see id.* at 691-696 (considering legislative history in determining severability); *see also Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010) (considering statute's "historical context" in determining severability). Here, that history is one of severely compromised or failed legislative efforts to implement market reforms without an adequate mandate of minimum individual insurance coverage.

In the 1990s, a number of States enacted individual market reforms, including guaranteed issue and various community rating requirements, without a minimum individual coverage requirement. The result in each State was a general destabilization of individual markets, increases in premiums, and declining enrollment.

For example, Maine enacted guaranteed issue and modified community rating reforms for its individual market in 1993, allowing limited price variation only for age, occupation or industry, and geographic location. *See* B. Gorman, *et al.*, *Reform Options for Maine's Individual Health Insurance Market: An Analysis Prepared for the Bureau of Insurance* 5 (May 30, 2007). According to the Maine Bureau of Insurance's report analyzing the ensuing problems, the "market for individual HMO coverage" as of January 2001 "appear[ed] to be in a death spiral." Maine Bureau of Insurance, *White Paper: Maine's Individual Health Insurance Market* 4 (Jan. 22, 2001). Premiums for indemnity coverage increased dramatically, *id.* at 4-7, and coverage rates plummeted as a result, dropping from an enrollment of 102,000 to 54,000 between 1994 and 2000. *See* U.S. Census Bureau, Historical Health Insurance Tables, Table HI-6 (1987—2005), *available at* http://www.census.gov/hhes/www/hlthins/data/historical/original.html. State regulators attributed those trends in part to the modified community rating requirement, which "result[ed] in the risk pool having a higher average age and therefore higher costs." Maine Bureau of Insurance, *supra*, at 10.

In Kentucky, adverse selection similarly contributed to significant destabilization of the individual market. Within two years of Kentucky's enactment of comprehensive insurance market reforms in 1994—including guaranteed issue and modified community rating requirements—more than forty insurers ended their participation in Kentucky's individual market, with only two insurers remaining to sell new policies in the individual market. Adele M. Kirk, *Riding the Bull: Experience With Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 J. Health Politics, Policy & Law 152 (2000).[13] Responding to the collapse of the individual market and fearing that many residents across the State no longer had coverage options, Len M. Nichols, *State Regulation: What Have We Learned So Far?*, 25 J. Health Politics, Policy & Law 175, 194 (2000), the Kentucky legislature began repealing the insurance reforms in 1997, eventually eliminating many of the reforms' core provisions, including guaranteed issue and modified community rating. *See* Kirk, *supra*, at 152, 158; Nancy C. Turnbull, *et al.*, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market: Short Case Studies of Six States* 7 (Feb. 2005) ("The 1998 reforms were meant to attract carriers back into the market and reduce rates for the healthy enrollees of existing carriers.").

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[13] Approximately 23 of these insurers were holding more than 100 individual policies but stopped selling new coverage when the reforms were enacted. Holding only a few or no policies, the rest of the insurers left Kentucky's individual market altogether. *See* Kirk, *supra*, at 152.

The deterioration of the insurance market likewise led the New Hampshire legislature eventually to repeal its reforms of the individual health insurance market. In 1994, New Hampshire enacted reforms that included guaranteed issue, modified community rating, and limits on preexisting condition exclusions. *See* Alexander K. Feldvebel & David Sky, *A Regulator's Perspective on Other States' Experiences*, 25 J. Health Politics, Policy & Law 197, 198 (2000). Between 1994 and 2000, the number of carriers participating in the individual market dropped from twelve to two, and the two insurers that remained offered individual policies at higher prices. *Id.* at 197, 199. In 1997, the New Hampshire Insurance Department characterized those market changes as a "market-wide antiselection spiral." David Sky, *High Risk Pool Alternatives: A Case Study of New Hampshire's Individual Health Insurance Market Reforms*, 16. J. Ins. Reg. 399, 401 (Summer 1998) (citing New Hampshire Insurance Department, *An Analysis of the Nongroup Market with Recommendations for Change* (Oct. 27, 1997)). In 2001, the New Hampshire legislature repealed the guaranteed issue requirement and allowed insurers once again to use medical underwriting for policies sold in the individual market. National Ass'n of Health Underwriters, *Analysis of State-Level Health Insurance Market Reforms* 11-12 (Oct. 2005).

Similarly, volatility in the individual market prompted the State of Washington to repeal the individual market reforms it had passed in 1993.

The 1993 reforms included a guaranteed issue provision, a phased-in community rating requirement, and limits on preexisting condition exclusions. *See* Kirk, *supra*, at 133, 136-137. In the ensuing three years, premiums in the individual market rose by as much as 78 percent. *See* Peter Suderman, *The Lesson of State Health-Care Reforms*, Wall St. J., Oct. 15, 2009, at A21. Over that same period, enrollment in Washington's individual market fell by 25 percent, *id.*, and the market retracted from having 19 private health insurers in 1993 to only three by 1999, Roger Stark, *Overview of the Individual Health Insurance Market in Washington State*, Washington Policy Center (Jan. 2011) at 1.

By September 1999, there were only two insurers offering individual health insurance, both of which announced their intention to stop selling individual policies in Washington because the reforms rendered it unviable for them to continue offering affordable coverage to consumers. Stark, *supra*, at 1 (explaining that by 1999 "the individual market had essentially collapsed"); *see* Press Release, Office of Governor Gary Locke, "Locke signs bill to revive individual health insurance market" (Mar. 23, 2000), *available at* http://www.digitalarchives.wa.gov/GovernorLocke/press/press-view.asp?pressRelease=283&newsType=1 ("The governor noted that he signed the law at a time when individuals in 36 of 39 counties cannot buy individual policies at any price."); *see also* Conrad F. Meier, *Universal Health Insurance in Washington State: A Grim Prognosis for All of Us*, Medical Sentinel (Mar./Apr. 2000).

Starkly demonstrating the problem of adverse selection, "Washington state also became a magnet for patients from around the country who had serious and expensive medical conditions because they knew they could get immediate health insurance coverage." Doug Ericksen and Roger Stark, *What Washington, D.C. Could Learn from Washington State Health Care Reform*, Washington Policy Center (July 2010). Additionally, many people took advantage of the system by, for example, changing from a low-cost health insurance plan with a high deductible to a high-coverage plan with a low deductible when they needed major medical treatment, and then changing back or dropping their coverage altogether after receiving the treatment. *Id.*; *see* Bill Richards, *Perils of Pioneering: Health-Care Reform In State of Washington Riles Nearly Everyone*, Wall St. J., Apr. 4, 1996, at A1 (describing cancellation letter insurer received from a Washington woman who praised the policy's maternity benefits and "would be sure to come back and get another [policy] if she got pregnant again").

As a result of the near "collapse" of the individual insurance market, the Washington legislature repealed the market reforms in 2001, and subsequently enacted legislation designed to encourage carriers to reenter Washington's individual market. *See* Robert Wood Johnson Foundation, *Issue Brief: Recognizing Destabilization in the Individual Health Insurance Market* 4 (July 2010).

Finally, in 1996, the Massachusetts legislature passed reforms, including guaranteed issue of certain benefit packages, a prohibition on preexisting condition exclusions and waiting periods, and a modified community rating system. Kirk, *supra*, at 161; *see also* Turnbull, *supra*, at 11. After those reforms were implemented, premiums rose and coverage rates fell, with enrollment in the individual market declining from approximately 135,000 people in 1996 to just over 55,000 in 2000. Turnbull, *supra*, at 13; *see also* Kirk, *supra*, at 167-68.

In 2000, the Massachusetts legislature began modifying those provisions, Turnbull, *supra*, at 13, culminating with the passage of a comprehensive health reform bill in 2006. S.K. Long, *On the Road to Universal Coverage: Impact of Reform In Massachusetts At One Year*, 27 Health Affairs w270, w270 (June 3, 2008). The 2006 reform package maintained some of the measures passed a decade earlier, including guaranteed issue and modified community rating, but added numerous new requirements, including a minimum individual coverage mandate that required every qualifying Massachusetts resident over the age of 18 to purchase health insurance. J.E. McDonough, *et al.*, *Massachusetts Health Reform Implementation: Major Progress and Future Challenges*, 27 Health Affairs w285, w291 (June 3, 2008).

Other States that enacted market reforms without an individual mandate in the 1990s experienced similar destabilization. *See* Monheit, *supra*, at 168 (as of 2004, New Jersey individual market was "heading for collapse"); Paul Howard, *Building a Market-Based Health-Insurance Exchange in New York*, Manhattan Institute for Policy

Research at 6-7 (Apr. 2011) (noting that "New York has one of the most expensive individual and small-group insurance markets in the country, largely as a result of its 1992 community-rating/open-enrollment" law, and explaining that regulatory policies like community rating "[o]ver time * * * can lead to a 'death spiral,' where the risk pool—and the market—collapses entirely (as it has in New York)"); Mark A. Hall, *An Evaluation of Vermont's Reform Law*, 25 J. Health Politics, Policy & Law 101 (2000) (Vermont); Elliott K. Wicks, *The Individual Market in Vermont: Problems and Possible Solutions* 15 (Dec. 2006) (reporting that the individual health insurance market in Vermont "seems to be performing badly: the number of people buying such coverage is falling drastically; coverage is unaffordable for many; and the only coverage that is available has very high cost sharing") (prepared for Vermont Department of Banking, Insurance, Securities and Health Care Administration); Susan Besio, *Vermont Health Care Reform: Five-Year Implementation Plan* 3, 10 (Dec. 1, 2006) ("[T]he Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, and limited carrier participation."); *see also* Les Masterson, *Indiana Program Shows Health Reform Without Individual Mandate Is Costly*, HealthLeaders Media (Sept. 9, 2009); Rob Damler, *Experience Under The Healthy Indiana Plan: The Short-Term Cost Challenges of Expanding Coverage to the Uninsured*, Milliman Health Reform Briefing Paper (Aug. 2009).

Congress enacted ACA and its minimum individual coverage provision against that backdrop of severely compromised and failed state efforts at mandate-less market reforms, and it aimed to inoculate its insurance-market reforms against the same adverse-selection and cost-shifting problems that had plagued the States by requiring a minimum level of individual insurance coverage. Indeed, Congress was expressly advised of the market disruptions that occurred with State reform efforts and the ensuing lesson that the minimum individual coverage mandate is "a critical linchpin * * * to the overall effort to reform the health care market and bring associated costs under control." 156 Cong. Rec. H1854, H1882 (daily ed. Mar. 21, 2010) (statement of Rep. Miller); *see, e.g., Covering the Uninsured: Making Health Insurance Markets Work: Hearing Before the S. Committee on Finance*, 110th Cong., 2d. Sess. 3 (2008) (statement of Pam McEwan, Executive Vice President, Public Affairs and Governance, Grp. Health Coop.) (noting that the absence of a minimum individual coverage mandate in Washington state during the mid-1990s effort to reform insurance markets "rapidly led to a classic adverse risk spiral in the marketplace").

Accordingly, when Congress labeled the mandate "essential" to the implementation of its insurance-market reforms, 42 U.S.C. § 18091(2)(I), that judgment was based on its knowledge that state efforts to implement similar insurance market reforms without the economic counterbalance of a minimum individual coverage requirement had not worked. Congress specifically found both that, "if there were no [minimum individual coverage mandate] requirement, many individuals would wait to purchase health insurance until they needed care," and that the mandate would help to "minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.*

In other words, Congress's finding that the mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold," 42 U.S.C. § 18091(2)(I), means exactly what it says. It embodies Congress's judgment that the minimum individual coverage provision and the insurance-market reforms regarding guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating are inseparable components of a unified legislative design that, for severability purposes, must rise or fall together. Indeed, implementation of ACA's market reforms in the absence of the minimum coverage provision would thwart Congress's central goal of increasing the availability of affordable health care coverage.

2. The Court of Appeals Failed to Focus on How Congress Intended the Mandate and Reforms to Function Together

The Eleventh Circuit reached a contrary result, holding that the mandate is entirely severable from the balance of ACA. Pet. App. 5a, 172a-186a. But the court was able to do so only because its analysis focused on whether a statute with insurance reforms but without a mandate could be operative or enacted as law. Of course it could. Many States passed such laws. But Congress knew that, without a mandate, they had produced disastrous results.

The relevant question for severability purposes, however, is whether the Congress that looked at those State experiences and labeled the mandate "essential" to the proper functioning of its insurance-market reforms would have intended, if the mandate were stricken, to replicate on a national level the profound adverse selection and cost-shifting problems that had afflicted State reform efforts. *See, e.g.*, *Booker*, 543 U.S. at 265. The court of appeals, in other words, failed to ask the right question about Congress's intended functioning of the law and, in so doing, never came to grips with the implications of Congress's knowledge of state reform efforts, and the proven, substantial risk of profound economic displacement and a "market-wide antiselection spiral" that the reforms would cause in the absence of a mandate.[14]

Tellingly, the federal government has agreed in previous briefing that the minimum individual coverage provision is not severable from ACA's guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating provisions. *See, e.g.*, No. 11-398, U.S. Pet. at 25 ("Indeed, no party to this case has suggested that the guaranteed-issue and community-rating requirements could function effectively without the minimum coverage provision."); Nos. 11-393, 11-400,

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[14] David Sky, *High Risk Pool Alternatives: A Case Study of New Hampshire's Individual Health Insurance Market Reforms*, 16 J. Ins. Reg. 399, 401 (Summer 1998).

U.S. Brief in Response at 10-11 (similar); Br. of United States, *Florida v. HHS*, Nos. 11-11021 & 11-11067 (11th Cir. Apr. 1, 2011) at 59 (recognizing "that the minimum coverage provision is integral to the Act's guaranteed-issue and community-rating provisions").[15]

Those insurance-market reforms not only cannot function as Congress intended if enforced without a minimum coverage mandate, but in fact would thwart congressional intent if left to operate alone. The Eleventh Circuit cited no case, and amici are aware of none, where severability was found in the face of such a plain textual linkage, express findings, extensive evidence of the catastrophic consequences of leaving just half of a legislated package intact, and the Executive Branch's judgment that specified provisions are inextricably bound together. This case should not be the first to cast aside such powerful evidence that the specified statutory provisions would not function as Congress intended, and indeed that severing the interconnected provisions within the statute would likely do significant harm.

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[15] The Government's briefs consistently use the term "guaranteed issue" as an umbrella term encompassing not only the guarantee of insurance for all qualified applicants, but also the prohibitions on preexisting-condition exclusions and other health-status discrimination in coverage eligibility. *See* No. 11-398, U.S. Pet. at 4 (describing fact that Act "will bar insurers from refusing coverage because of a pre-existing medical condition" as the "guaranteed-issue" provision, and citing to both 42 U.S.C. § 300gg-1, the guaranteed issue provision, and 42 U.S.C. § 300gg-3, the provision barring preexisting condition exclusions); Nos. 11-393, 11-400, U.S. Resp. Br. 4 (same), 10, 31-32 (arguing that, without the individual mandate, "the guaranteed-issue and community-rating provisions would not advance Congress's efforts to make affordable coverage widely available," citing to Congress's finding in 42 U.S.C. § 18091(2)(I) that the prohibitions on preexisting condition exclusions (PHSA § 2704, 42 U.S.C. § 300gg-3) and other health status discrimination in coverage eligibility (PHSA § 2705, 42 U.S.C. § 300gg-4), standing alone, would lead to adverse selection).

* * * * *

Should this Court strike the mandate and have to address the severability question, then this Court must determine whether "different clauses of [the] act are so dependent upon" the minimum individual coverage mandate "that it is evident the legislature would not have enacted one of them without the other," *Huntington v. Worthen*, 120 U.S. 97, 102 (1887), and whether those additional provisions could, standing alone, "function in a manner consistent with the intent of Congress," *Alaska Airlines*, 490 U.S. at 685 (emphasis omitted). In undertaking that analysis, this brief addresses only the insurance-market reform provisions with which AHIP, Blue Cross Blue Shield, and their members have direct experience both generally and in particular with respect to reform efforts at the state level. Based on that expertise, at a minimum, the insurance-market reforms implemented by ACA cannot function as Congress intended without the individual coverage requirement and, in fact, would likely impede Congress's goal of ensuring affordable universal health care if left to operate on their own. Those market reforms include the guaranteed issue provision (42 U.S.C. § 300gg-1), the provisions prohibiting waiting periods, preexisting condition exclusions, and other health status discrimination

(42 U.S.C. §§ 300gg-3, 300gg-4), and the adjusted community rating provision (42 U.S.C. § 300gg(a)). The insurance-market reforms are thus inseverable from the minimum individual coverage provision and would have to be stricken from ACA if the individual coverage requirement were to be invalidated.

CONCLUSION

For the foregoing reasons, if this Court invalidates the minimum individual coverage provision, 26 U.S.C. § 5000A, the court of appeals' severability judgment should be reversed and, with respect to the minimum individual coverage mandate's operation, this Court should sever, along with Section 5000A, ACA's guaranteed issue, preexisting conditions, health-status discrimination, and adjusted community rating provisions.

Respectfully submitted.

Roger G. Wilson
Senior Vice-President
& General Counsel
BLUE CROSS BLUE SHIELD
ASSOCIATION
225 N. Michigan Ave.
Chicago, IL 60601
(312) 297-6000

Counsel for Blue Cross Blue Shield Association

Patricia A. Millett
Counsel of Record
Orly Degani
James E. Tysse
AKIN, GUMP, STRAUSS,
HAUER & FELD LLP
1333 New Hampshire
Avenue, N.W.
Washington, DC 20036
(202) 887-4000
pmillett@akingump.com

Joseph Miller
Julie Simon Miller
AMERICA'S HEALTH
INSURANCE PLANS
601 Pennsylvania
Avenue, N.W.
South Bldg., Suite 500
Washington, DC 20004
(202) 778-3200

Counsel for America's Health Insurance Plans

January 6, 2012

AMICUS
CURIAE
BRIEF

Nos. 11-393 & 11-400

IN THE
Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS,
KAJ AHLBURG, AND MARY BROWN,
Petitioners,

v.

KATHLEEN SEBELIUS, *et al.*,
Respondents.

STATE OF FLORIDA, *et al.*,
Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES, *et al.*,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM, *ET AL.*, IN SUPPORT OF COURT-APPOINTED *AMICUS CURIAE* (SEVERABILITY ISSUE)

MEE MOUA
PRISCILLA HUANG
ASIAN & PACIFIC ISLANDER
AMERICAN HEALTH FORUM
1828 L Street, N.W.
Suite 802
Washington, DC 20036
(202) 466-7772

MARK A. PACKMAN
Counsel of Record
JONATHAN M. COHEN
KAMI E. QUINN
ALYSON A. FOSTER
MICHELLE A. PRICE
JENNA A. HUDSON
GILBERT LLP
1100 New York Avenue, N.W.
Suite 700
Washington, DC 20005
(202) 772-2320
packmanm@gotofirm.com

Counsel for Amici Curiae

[Additional *Amici* listed on inside cover]

AIDS Services in Asian Communities
Asian American Cancer Support Network
Asian American Health Coalition-HOPE Clinic
Asian & Pacific Islander Coalition on HIV/AIDS, Inc.
Asian & Pacific Islander National Cancer Survivors Network
Asian & Pacific Islander Wellness Center
Asian Health Services
Asian Pacific AIDS Intervention Team Health Center
Asian Pacific American Network of Oregon
Asian Pacific Community In Action
Asian Services In Action, Inc.
Asians and Pacific Islanders with Disabilities of California
Center for Pan Asian Community Services, Inc.
Coalition for Asian American Children and Families
Council for Native Hawaiian Advancement
Empowering Pacific Islander Communities
Filipino Community Cancer Collaborative
Guam Communications Network
Hawai'i Island HIV/AIDS Foundation
Kalusugan Coalition
Lao Assistance Center of Minnesota
Light and Salt Association
Malama Pono Health Services
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National Tongan American Society
Native Hawaiian and Pacific Islander Alliance
New Mexico Asian Family Center
Orange County Asian and Pacific Islander Community Alliance, Inc.
Pacific Islands Primary Care Association
Project CHARGE
Saath USA
Samoan Community Development Center
Samoan National Nurses Association
Taulama For Tongans
TOFA Inc.
Tongan Community Service Center
Vietnamese American Young Leaders Association of New Orleans
WAPI Community Services
West Michigan Asian American Association

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Since 1986, the Asian & Pacific Islander American Health Forum ("APIAHF") has influenced policy, mobilized communities, and strengthened programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders. As part of an ambitious framework for achieving health equity and addressing health disparities in Asian American, Native Hawaiian, and Pacific Islander communities, APIAHF's national policy work focuses on expanding access to health care, improving the quality of health care through cultural competency and language access, increasing research, and improving the collection, reporting, and analysis of data about our communities. APIAHF's work is possible through partnerships with community-based organizations, community leaders, health care providers and researchers, and other minority and immigrant health advocates.

The Patient Protection and Affordable Care Act ("Affordable Care Act" or the "Act") will reduce the number of uninsured Americans and provide better coverage options for those who need it the most. Additionally, the Act will improve the quality of care available to marginalized communities. APIAHF's advocacy efforts to promote fairness, respect, equity, and health justice lead to its authorship of this *amicus* brief.

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[1] In accordance with Supreme Court Rule 37.6, *Amici Curiae* note that the position they take in this brief has not been approved or financed by Petitioners, Respondents, Court-Appointed *Amicus Curiae*, nor their counsel. Neither Petitioners, Respondents, Court-Appointed *Amicus Curiae*, nor their counsel had any role in authoring, nor made any monetary contribution to fund the preparation or submission of, this brief. Pursuant to Supreme Court Rule 37.3, *amici curiae* state that all parties have consented to the filing of this brief; blanket letters of consent have been filed with the Clerk of the Court.

Joining APIAHF as *amici curiae* are thirty-nine additional public interest groups that focus on issues impacting Asian American, Native Hawaiian, and Pacific Islander communities (collectively, "*Amici*"). The statements of interest of these additional *Amici* are included in Appendix A.

INTRODUCTION AND SUMMARY OF ARGUMENT

This brief supports the position of Court-Appointed *Amicus Curiae* H. Bartow Farr, III. Multiple states and private entities have challenged the constitutionality of the Affordable Care Act's minimum coverage provision, which requires all individuals to procure and maintain health insurance. Although undersigned *Amici* believe that Congress had constitutional authority to enact the minimum coverage provision, they submit this brief in support of severability because the other reforms of the Affordable Care Act make substantial progress toward Congress's goal of improving access to quality, appropriate, and affordable health care. As the Eleventh Circuit determined, the Affordable Care Act is fully functional without the minimum coverage provision. *Amici* accordingly agree with the Eleventh Circuit that, if the Court finds the minimum coverage provision unconstitutional, it should sever the provision and leave the remainder of the Affordable Care Act intact.

If the Court finds that the minimum coverage provision is unconstitutional, the Court will need to determine whether "the legislature [would] have preferred what is left of its statute to no statute at all." *See Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006) (citations omitted). The Court will need to review Congress's original goals and determine "whether the statute will function in a *manner* consistent with the intent of Congress" without the unconstitutional provision. *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685

(1987); *Regan v. Time, Inc.*, 468 U.S. 641, 652-53 (1984).

In making these determinations, the Court will begin with the principle that an unconstitutional provision is presumptively severable. *See Regan*, 468 U.S. at 652-53. The Court therefore will leave intact constitutionally valid provisions that are "fully operative as law," unless "it is evident that [Congress] would not have enacted those provisions" but for the unconstitutional provision. *Id.* at 653 (citations omitted).

Here, it is clear that Congress would prefer that the remaining provisions of the Affordable Care Act remain intact even if the Court finds that the minimum coverage provision is unconstitutional. Congress passed the Affordable Care Act to improve access to quality, appropriate, and affordable health care for all Americans. This includes minorities such as Asian Americans, Native Hawaiians, and Pacific Islanders, who, as Part I below demonstrates, are inadequately served by the current health care system. For example:

- Asian Americans, Native Hawaiians, and Pacific Islanders are more likely to be uninsured than non-Hispanic white Americans.

- Because of unique cultural and language barriers, Asian Americans, Native Hawaiians, and Pacific Islanders do not receive the recommended levels of preventive health care, counseling, or routine treatment.

- Disaggregated data reveal that ethnic subgroups within these communities are particularly disadvantaged in their access to meaningful health care.

Additionally, as the real-world experiences of the Asian American, Native Hawaiian, and Pacific Islander individuals described in Part II demonstrate, the Affordable Care Act will reduce the burdens that the current health care system places on all Americans. For example,

- The Affordable Care Act will enable more Americans to obtain health insurance coverage as individuals, through their employers, and from federal and state governments.
- The Affordable Care Act will help Americans access culturally and linguistically appropriate services and providers.
- The Affordable Care Act will help researchers, health care providers, and federal and state governments identify and reduce health disparities through expanded data collection and reporting.

Reducing these burdens on access to health care is critically important. There is no evidence that Congress would refuse to enact these crucial reforms even if the minimum coverage provision is held unconstitutional.

In sum, even without the minimum coverage provision, the Affordable Care Act is "fully operative as law." ***Regan***, 468 U.S. at 653. It is not "evident" that Congress would have enacted the remaining provisions of the Affordable Care Act only in conjunction with the minimum coverage provision. *See id.* To the contrary, the evidence demonstrates that Congress would prefer that the Affordable Care Act remain intact and serve the goals of reducing barriers to health care even without the minimum coverage provision. Accordingly, even if this Court were to hold that the minimum coverage provision is unconstitutional, it should sever that provision and uphold the remainder of the Affordable Care Act.

ARGUMENT

I. ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS HAVE UNIQUE HEALTH CARE NEEDS AND DISPROPORTIONATELY LESS ACCESS TO QUALITY, APPROPRIATE, AND AFFORDABLE HEALTH CARE.

More than 18 million Asian Americans, Native Hawaiians, and Pacific Islanders live in the United States and its jurisdictions. *Demographic and Socioeconomic Profiles of Asian Americans, Native Hawaiians, and Pacific Islanders in the United States*, APIAHF, 2 (July 2011), http://www.apiahf.org/sites/default/files/Demographi c_Socioeconomic_Profiles_AANHPI.pdf (“*Demographic and Socioeconomic Profiles*”). Many of these people face unique challenges in obtaining meaningful health care.

Fourteen percent of Asian Americans, Native Hawaiians, and Pacific Islanders lack any form of health insurance. *The Impact of Health Care Reform on Health Coverage for Asian Americans, Native Hawaiians, and Pacific Islanders*, APIAHF, 1 (Dec. 2011), http://www.apiahf.org/sites/default/files/PA-Factsheet12-2011.pdf (“*Impact of Health Care Reform*”) (citation omitted). This number is even higher within specific ethnic groups; over 20% of Bangladeshi, Cambodian, Korean, and Pakistani Americans. *Id.* Additionally, as many as 65.7% of Chinese Americans living in the western United States, are uninsured. *See* Chau Trinh-Shevrin et al., *Asian American Communities And Health: Context, Research, Policy and Action*, 353-54 (Albert K. Yee et al., eds., 2009).

In addition, Asian American, Native Hawaiian, and Pacific Islander children are uninsured and underinsured at unacceptably high rates. Approximately 8% of Asian American children and 11% of Native Hawaiian or Pacific Islander children are uninsured. *See Coverage Gains For Asian American, Native Hawaiian and Pacific Islander Children Under Health Care Reform*, APIAHF, 1 (Sept. 2011), http://www.apiahf.org/sites/default/files/PA-factsheet09-2011_0.pdf. Among all racial groups, Asian American children have the highest rate of underinsurance, at 28%. *Id.* at 2 (citation omitted).

These high rates of uninsurance and underinsurance result from a variety of factors. Michael D. Kogan et al., *Underinsurance Among Children in the United States*, 363 New Eng. J. Med. 841, 841-51 (2010). In many cases, individuals in these communities are self-employed and cannot afford individual coverage, or are employed at small businesses that do not provide health insurance. Trinh-Shevrin et al., *supra*, at 346.

Many Asian Americans, Native Hawaiians, and Pacific Islanders are simply unable to afford health insurance and/or health care. Although some subgroups of this population enjoy economic success and stability, others struggle with severe poverty. For example, whereas only approximately 5% of Filipino families have incomes below the poverty line, approximately 25% of Hmong American (an ethnic group from China, Vietnam, Laos, and Thailand) families have incomes below the poverty line. *See Demographic and Socioeconomic Profiles*, *supra*, at 11. Approximately 56% of all Asian Americans have personal incomes under 400% of the Federal Poverty Level. *Current Population Survey: 2011 Annual Social and Economic Supplement: Asian Alone*, U.S. Census Bureau, (2011), http://www.census.gov/hhes/www/cpstables /032011 /pov/new01_400_08.htm. Further, 15.1% of Native Hawaiians and Pacific Islanders live in poverty. *Facts for Features: Asian / Pacific American Heritage Month: May 2011*, U.S. Census Bureau News, 3 (March 8, 2011), http://www.census.gov/ newsroom/releases/pdf/cb11ff-06_asian.pdf.

When members of these communities attempt to access health care, they face unique barriers. For example, roughly one out of every three Asian Americans, and nearly one in seven Asian American children, has limited English proficiency and experiences some difficulty communicating in English. *2008-2010 American Community Survey 3-Year Estimates: Nativity By Language Spoken At Home By Ability To Speak English For the Population 5 Years And Over (Asian Alone),* U.S. Census Bureau (2010), http://www.arcticstat.org/TableViewer.aspx?S=1&ID=7996.

Finally, Asian Americans, Native Hawaiians, and Pacific Islanders experience disproportionate rates of multiple types of cancer, mental health conditions, Hepatitis B, and other diseases. *Asian American Health Concerns*, Asian Am. Health Initiative, http://aahiinfo.org/about-asian-americans/asian-american-health-concerns/ (last visited January 26, 2012); *see also Priorities in Health Care Reform for Asian American, Native Hawaiian, and Pacific Islander Communities*, APIAHF, 1 (Feb. 2010), http://www.apiahf.org/sites/default/files/PA_HealthBrief02_2010.pdf ("*Priorities in Health Care Reform*"). Pacific Islander communities also are at disproportionate risk for cardiovascular disease, obesity, and diabetes. Trinh-Shevrin et al., *supra*, at 177, 181, 183.

The Affordable Care Act will improve access to quality, appropriate, and affordable health care. The availability of health insurance will contribute to meeting this goal. Not surprisingly, there is a strong correlation between those who have insurance and those who have access to health care: as many as 96% of Asian Americans, Native Hawaiians, and Pacific Islanders who have health insurance regularly access medical care, as compared to only 47% of those who are uninsured. *See* E. Brown et al., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care*, UCLA Center for Health Policy Research and The Henry J. Kaiser Family Found. (2000), http://www.kff.org/uninsured/upload/Racial-and-Ethnic-Disparities-in-Access-to-Health-Insurance-and-Health-Care-Report.pdf. Even beyond increasing the availability of health insurance, the Affordable Care Act "includes a number of provisions that will improve the health of racial and ethnic minorities and other vulnerable populations." *Report to Congress: Report on Minority Health Activities As Required by the Patient Protection and Affordable Care Act, P.L. 111-148*, Office of Minority Health, Dept. of Health & Human Servs., vi (2011), http://www.healthcare.gov/law/resources/reports/minorities03252011a.pdf. ("*Report to Congress*").

Part II demonstrates how Congress intended multiple provisions of the Affordable Care Act to address such disparities and establishes that each operates and serves Congress's goals independently of the minimum coverage provision.

II. THE AFFORDABLE CARE ACT IMPROVES ACCESS TO HEALTH CARE FOR ALL THROUGH COMPREHENSIVE REFORMS THAT OPERATE INDEPENDENTLY FROM THE MINIMUM COVERAGE PROVISION.

Congress designed the Affordable Care Act to address, among other failures of the national health care market, the costs that the current health care system imposes on society as a whole, as well as the disparities that minorities experience in health and health care. To remedy these failures, the Act includes both (A) broad reforms designed to alleviate burdens created by the existing health care system market and improve health insurance and health care benefits and (B) more focused reforms designed to create a framework to address health care issues unique to minority populations. The focused reforms are largely based on previous legislation proposed by minority caucuses. Together, these broad and focused changes help remedy failures of the existing health care system and address disparities in minority access to quality, appropriate, and affordable health care.

A. Many Provisions Of The Affordable Care Act Directly Remedy The Current System's Burdens On Society While Increasing Access To Meaningful Health Insurance And Health Care For All Americans.

The current health care system imposes a burden on society that multiple provisions of the

Affordable Care Act help alleviate. High health care costs force many Americans who are unable to afford health care to pass their costs to others in society. *See* David Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 Am. J. of Med. 741, 741 (2009). In 2007, 62% of individuals who filed for bankruptcy did so as a result of high medical costs or medical-related issues. *Id.* Researchers at the Urban Institute recently estimated that the Affordable Care Act will halve the national costs of providing uncompensated care. Fredric Blavin et al., *State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain: Timely Analysis of Immediate Health Policy Issues*, Urban Institute, 3 (2012), http://www.urban.org/Uploaded PDF/412485-state-progress-report.pdf. Currently, the federal government bears 45% of those costs, state and local governments bear 30% of those costs, and health care providers bear 25% of those costs. *Id.* Health issues create an estimated $260 billion per year of lost economic output in the United States, which equals about 2.4% of the gross domestic product. Karen Davis et al., *Health and Productivity Among U.S. Workers*, The Commonwealth Fund, 4 (2005), http://www.commonwealthfund.org/usr_doc/856_Davis_hlt_productivity_USworkers.pdf.

The Affordable Care Act also improves access to health insurance and health care. The Act both benefits all Americans and remedies the disparate access of minorities to meaningful health insurance and health care through, among other provisions: (1) the Small Business Health Options Program

("SHOP") and small business tax credits; (2) the expansion of Medicaid; (3) the premium tax credit; (4) the dependent coverage provision; and (5) the collection of provisions that bar private insurers from denying coverage or charging higher premiums based on an applicant's medical condition. While helping all Americans, these provisions reform the health care system in ways that will benefit millions of previously underserved Asian Americans, Native Hawaiians, and Pacific Islanders. Indeed, the experiences of individuals within these communities demonstrate that many people already have benefited from the Act and that these provisions are "fully operative as law" without the minimum coverage provision. *See Regan*, 468 U.S. at 653.

1. The SHOP And Small Business Tax Credits Will Enable Over 1.5 Million Asian American, Native Hawaiian, And Pacific Islander Small Business Owners To Provide Health Care For Their Families And Employees.

The SHOP and small business tax credit provisions help small business owners and their employees access affordable, quality health insurance. *See* 42 U.S.C. § 18031 (2010). The SHOP will enable small business owners to offer their employees a choice among multiple qualified health plans. *Id.* The SHOP finds qualified health plans, obtains cost and benefit information, enrolls employees, and allows for consolidated billing, relieving employees of these costs and burdens. *Affordable Insurance Exchanges: Choices,* *Competition and Clout for Small Businesses*, HealthCare.gov, http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011c.html (last visited Dec. 30, 2011). The Affordable Care Act further helps small business owners with fewer than twenty-five full-time employees who provide health insurance coverage to their employees by providing the owners with a health insurance premium tax credit. *Id.*

Asian Americans, Native Hawaiians, and Pacific Islanders are in particular need of small business credits. The percentage of Asian Americans, Native Hawaiians, and Pacific Islanders with employment-based health insurance is lower than the percentage of non-Hispanic whites. *See* Trinh-Shevrin et al., *supra*, at 346. This is because Asian Americans, Native Hawaiians, and Pacific Islanders are more likely than non-Hispanic whites to be self-employed, unable to afford health insurance, or employed by small businesses that cannot afford to provide it. *Id.* In fact, more than 1.5 million Asian Americans, Native Hawaiians, and Pacific Islanders own or work for small businesses. *See* Press Release, U.S. Census Bureau, *Census Bureau Reports the Number of Asian-Owned Businesses Increased at More Than Twice the National Rate* (April 29, 2011), http://www.census.gov/newsroom/releases/archives/business_ownership/cb11-74.html. Especially high numbers of Korean Americans are self-employed or work for small businesses. A survey of Korean American small shop owners revealed that 52% could not afford to provide a health plan for their employees, and 30% could not afford health coverage for their

dependents, including children. Deeana Laurie Jang, *Plug Coverage Gap*, ModernHealthcare.com (March 11, 2010, 10:30 am), http://www.modernhealthcare.com/article/20100311/news/303119951, *available at* http://www.apiahf.org/sites/default/files/Modern_Healthcare_03_11_10.pdf .

The individual experience of Tai Kyun Kim illustrates the immediate need for the SHOP and small business tax credit provision. Mr. Kim emigrated from North Korea and now owns and operates a small fish-fry restaurant in Union City, Georgia. Mr. Kim already has suffered one heart attack. He and his wife have accumulated $30,000 in unpaid medical bills and cannot afford to pay out of pocket for care known to lower the risk of a second heart attack. In addition, the Kims cannot find affordable group health insurance for their employees, a gap that leaves four employees and their dependent children at risk. The employees and their children often end up in emergency rooms. They, like millions of other uninsured Americans, rely on such trips for care that is needlessly expensive and fails to prevent chronic conditions from getting worse. *Id.* Under the Affordable Care Act, the Kims will be able to access the SHOP and gain health coverage for their family and employees.

Under *Regan*, to hold that a "fully operative" provision of the Affordable Care Act is not severable, it must be "evident" that Congress would not have enacted that provision without the minimum coverage provision. *See* 468 U.S. at 653. As the Eleventh Circuit noted, that standard is not satisfied here. *See* Pet. App. 11-393 at 196a (holding that all provisions of the Affordable Care Act are "fully operative as law" without the minimum coverage provision).

2. The Medicaid Expansion Provision Will Help Over One Million Previously Uninsured Asian Americans, Native Hawaiians, And Pacific Islanders.

The Affordable Care Act standardizes eligibility for Medicaid to all Americans under 65 (and their families) with incomes less than 133% of the Federal Poverty Level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2010). Prior to the Affordable Care Act, Medicaid eligibility requirements varied by state. *A Summary of the Health Reform Law*, Families USA, 3 (April 2010), http://www.familiesusa.org/assets/pdfs/health-reform/summary-of-the-health-reform-law.pdf. Prior to the Affordable Care Act, thirty-nine states did not provide Medicaid benefits to adults without dependent children. *Id.*

The Affordable Care Act's standardization of the Medicaid eligibility requirement will greatly benefit Asian Americans, Native Hawaiians, and Pacific Islanders. As of December 2011, almost 10% of Asian Americans and approximately 14% of Native Hawaiians and Pacific Islander Americans received health care through Medicaid. *See Impact of Health Care Reform*, *supra*, at 3. Dennis Chau, an eighteen-year-old Chinese American from

Houston, Texas, explains how life changed after his family no longer qualified for Medicaid due to his state's law:

> When our family didn't qualify for governmental insurance [anymore], we found ourselves foregoing quality over economy. The number of doctors changed as often as the seasons, and price was always weighing heavily on our minds. Life was always "be careful, you know you don't have insurance" and even ["]don't get sick, it'll be hard to pay for the costs if you do.["] It's just been so long without insurance that this seems like reality, and the days of coverage aren't really more than a dream.

Stories From Our Communities: Dennis Chau, APIAHF, http://www.apiahf.org/node/845 (last visited Feb. 14, 2012).

Under the Affordable Care Act's Medicaid expansion provisions, an estimated additional 9% of Asian Americans and 13% of Native Hawaiians and Pacific Islanders, totaling almost 1.3 million people, will gain coverage. *Impact of Health Care Reform*, *supra*, at 3 (citation omitted). This provision is "fully operative as law" and it is not "evident" that Congress would forgo including this provision without the minimum coverage provision. *See Regan*, 468 U.S. at 653; Pet. App. 11-393 at 196a ("The Act's other provisions remain legally operative after the [minimum coverage provision's] excision, and the high burden needed under Supreme Court precedent to rebut the presumption of severability has not been met.").

3. The Premium Tax Credit Provision Will Help Over One Million Medicaid-Ineligible Asian Americans, Native Hawaiians, And Pacific Islanders Obtain Health Insurance.

The Affordable Care Act's tax credit for Americans with incomes between 133% and 400% of the Federal Poverty Level will help those who are ineligible for Medicaid afford insurance coverage. 26 U.S.C. § 36B (2010). These qualifying individuals and families will receive refundable tax credits to help offset part of the costs of their health insurance premiums. *Id.* The size of the tax credit depends on the tax-filer's income; those with lower incomes will receive more assistance. *Id.* These tax subsidies likely will benefit up to 25% of Asian Americans, Native Hawaiians, and Pacific Islanders. *Impact of Health Care Reform*, *supra*, at 4. This provision, too, is "fully operative as law" without the minimum coverage provision, and it is not "evident" that Congress would forgo including it without the minimum coverage provision. *See Regan*, 468 U.S. at 653; Pet. App. 11-393 at 196a.

4. The Dependent Coverage Provision Will Help Many Asian American, Native Hawaiian, And Pacific Islander Young Adults Receive Health Insurance.

The Affordable Care Act mandates that, starting in September 2010, private individual or group insurers that offer dependent coverage to children of covered parents must allow children up to age twenty-six to stay on their parents' health insurance plans. 42 U.S.C. § 300gg-14 (2010); *Explaining Health Care Reform: Questions About the Extension of Dependent Coverage to Age 26*, The Henry J. Kaiser Family Found., 1 (May 2010), http://www.kff.org/healthreform/upload/8065.pdf ("*Explaining Health Care Reform*"). These children must demonstrate that they do not have coverage through their own employer, but they no longer need be students, and their parents need not claim them as dependents for tax purposes. *Explaining Health Care Reform*, *supra*, at 1. Previously, children over the age of nineteen were only allowed to be on their parents' health insurance plans while they were students. *Impact of Health Care Reform*, *supra*, at 5. The dependent coverage provision is especially important because the economic downturn has made it difficult for many young adults to find and afford health coverage. *Health Coverage for Young Adults: Health Reform Allows You to Stay on Your Parent's Health Plan*, Families USA, (2011), http://www.familiesusa.org/assets/pdfs/health-reform/coverage-for-young-adults.pdf.

Before the Affordable Care Act, almost 25% of Asian Americans and 30% of Native Hawaiians and Pacific Islanders between the ages of eighteen and twenty-four were uninsured. *Impact of Health Care Reform*, *supra*, at 5. The Affordable Care Act undoubtedly will help many of the 300,000 young adults in these communities obtain insurance. *Id.* This includes Jessica Huang, who attends a public university and works for a small business, both part-time. She is not eligible for health insurance through her school or her employer:

> For many young adults like me, it's particularly difficult to afford insurance working in entry-level, low-wage or temporary jobs. It's even harder when you are also going to school . . . . A few years ago, I discovered that my right kidney was abnormally small and filled with about a dozen stones that were trying to pass from the kidney. I had emergency surgery to remove the kidney and was lucky that I was covered under my father's insurance because it would have cost $34,000. I now need regular check-ups and a contrast CT scan every two years to make sure my remaining kidney is still functioning. I was dropped from my father's insurance when I turned 25 last year and spent several months without those regular checkups—worrying and hoping that I would not have another emergency. Because health care reform requires private insurers to cover young adults up to age 26 [] through their parent's insurance plan, I will

> be able to afford the contrast CT scan this year.

Stories From Our Communities: Jessica Huang, APIAHF, http://www.apiahf.org /jessica-huang (last visited Feb. 15, 2012). Not only will the dependent coverage provision help many Americans, but, this provision is "fully operative as law," and it is not "evident" that Congress would forgo including it without the minimum coverage provision. *See Regan*, 468 U.S. at 653; Pet. App. 11-393 at 196a.

5. The Provisions Barring Private Insurers From Denying Coverage Or Charging Higher Premiums Based On An Applicant's Medical Condition Will Enable Millions of Previously Uninsured Asian Americans, Native Hawaiians, And Pacific Islanders To Obtain Health Insurance And Thus Health Care.

Before Congress enacted the Affordable Care Act, health insurance companies routinely denied individual health insurance coverage, or charged exorbitant premiums, to individuals with certain preexisting conditions. The Affordable Care Act alleviates this problem in three main ways. First, the Act bars private insurers from denying coverage based on preexisting conditions. Since 2010, the Act has required all employer-sponsored health plans and new individual policies to provide coverage to all persons under age nineteen without regard to preexisting conditions. From 2010 to 2014, the Act provides coverage through state- and federal-run health programs for individuals over nineteen-years-old who have been unable to procure private insurance because of a preexisting condition. 42 U.S.C. § 300gg-3 (2010). After 2014, the Act will require private insurers that participate in state health insurance marketplace exchanges to provide coverage to individuals of all ages with preexisting conditions. *Id.* Second, the Act prohibits private insurers from charging higher premiums based on an insured's medical condition. *See* 42 U.S.C. §§ 300gg-4(b); 300gg(a)(1) (2010). Third, the Act requires all private insurers that operate in an individual or group market to accept every application for insurance coverage that they receive. *Id.* These provisions comprehensively protect individuals who previously were unable to obtain or afford insurance coverage based on their health status.

Such coverage is critically important in Asian American, Native Hawaiian, and Pacific Islander communities where chronic disease is widespread. Thirty percent of Asian Americans have asthma, diabetes, or hypertension. *Impact of Health Care Reform*, *supra*, at 4. Fifty percent of Americans with Hepatitis B are Asian American, Native Hawaiian, or Pacific Islander. *Id.* These communities experience disproportionate rates of cervical cancer, breast cancer mortality, stomach cancer, liver cancer, mental health conditions, Hepatitis B, and other diseases. *Asian American Health Concerns*, *supra*; *see also Priorities in Health Care Reform*, *supra*, at 1. Pacific Islander communities also suffer disproportionate rates of cardiovascular disease, obesity, and diabetes risk. Trinh-Shevrin et al., *supra*, at 177, 181, 183.

The experiences of members of Asian American, Native Hawaiian, and Pacific Islander communities and their health care providers demonstrate the direct and substantial impact of the Act's provisions that remove barriers to coverage.

Anton Saleh, a 16-year-old of Filipino descent from Southern California, reports receiving life-changing benefits from the guaranteed issuance of coverage provision:

> Before health care reform, I was unable to afford my prescription medications because my cancer medications were not on my insurer's approved drug list. The drugs I must take to treat my cancer cost $40+ per capsule and I presently take 4 per day, though this may soon increase to 6. At present, the cost of my medication is nearly $5,000 per month, which was $60,000 per year. Despite knowing that this medication is necessary to save my life, [my previous insurer] has repeatedly declined further support. We even tried to get the manufacturer of the drug to place me in a program that would have reduced the cost of my prescription, but they politely declined citing my age as the reason.

> My parents, of course, did whatever they could to find the funds to pay for my treatments. In fact, my father sold our family home, which he had lived in for 50 years, to make certain we had the money for my medicine. We also found we could order the same medication from an overseas supplier in the UK for roughly half the cost. It took my father months to comb through the various questionable online offerings and vet their reliability but it did payoff with a lower cost provider.
>
> In April of [2011], thanks to [the Affordable Care Act], we were able to change insurers. We now have insurance that covers much more of my prescription costs.

Stories From Our Communities: Anton Saleh, APIAHF, http://www.apiahf.org/node/844 (last visited Feb. 14, 2012).

The Asian & Pacific Islander Coalition on HIV/AIDS similarly reports that its patients already have received greater access to health insurance and services under the Affordable Care Act. For example, one health care provider recalls an uninsured, HIV-positive patient who had rapidly growing disfiguring masses on his face and neck, and needed a biopsy and a CT-scan immediately. The patient had three options: buy private insurance, go to a private surgeon and pay out of pocket, or wait three months for an appointment at the hospital. Prior to the Affordable Care Act, even if he had been able to purchase private health insurance, preexisting coverage restrictions would have forced him to wait up to a year for treatment. The patient did not have the financial resources to pay out of pocket for a private surgeon, and he could not wait the three months before he would be able to get an appointment at a hospital. However, because of the Affordable Care Act, he enrolled in his state's program for individuals with preexisting conditions. Once he obtained this coverage, he received a biopsy and CT scan within two days. His medical provider was then able to identify and treat his condition. *See Stories From Our Communities: Asian & Pacific Islander Coalition on HIV/AIDS*, APIAHF, http://www.apiahf.org/asian-pacific-islander-coalition-hiv/aids (last visited Feb. 14, 2012).

As these reports show, the provisions of the Affordable Care Act that bar private insurers from denying coverage or charging higher premiums based on an applicant's medical condition will have a momentous impact on the millions of Asian Americans, Native Hawaiians, and Pacific Islanders who are currently uninsured.

Further, as the Eleventh Circuit determined, these provisions are fully functional without the minimum coverage provision. Although Congress included the minimum coverage provision in part to mitigate the financial burden that provisions barring private insurers from denying coverage or charging higher premiums based on an applicant's medical condition place on those insurers, *see* 42 U.S.C. § 18091(a)(2)(I) (2010), the minimum coverage provision is not the only provision that will alleviate that burden. The Affordable Care Act contains provisions "apart from and independent of" the minimum coverage provision that encourage Americans to purchase insurance coverage, including provisions removing substantial barriers to coverage for Americans who do want health care coverage. *See* Pet. App. 11-393 at 189a (citing numerous provisions, including 26 U.S.C. §§ 36B, 4980H (2010); 29 U.S.C. § 218A (2010); 42 U.S.C. §§ 18071, 18031(d)(4)(d) (2010)). Furthermore, the minimum coverage provision would not entirely eliminate the burden that these provisions pose to private insurers; it includes three exemptions to the requirement that individuals maintain minimum coverage and five situations under which individuals would not be penalized for non-compliance. *See* Pet. App. 11-393 at 190a; *see also* 26 U.S.C. § 5000A(d), (e) (2010).[2]

There is no question that the provisions that bar private insurers from denying coverage or charging higher premiums based on an applicant's medical condition—like the SHOP provision, the Medicaid expansion provisions, and the other provisions discussed above—can operate without, and are "fully operative" without, the minimum coverage provision. *See Regan*, 468 U.S. at 653. It is far from "evident" that Congress would have elected not to make these critical and beneficial reforms in the absence of the minimum coverage provision. *See id.*

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[2] The Eleventh Circuit addressed only two of the provisions that require private insurers to provide health insurance without excluding coverage for preexisting medical conditions. *See* Pet. App. 11-393 at 184a (citing 42 U.S.C. §§ 300gg-1, 300gg-3). This same rationale applies, however, to all five of the above-listed provisions, which together bar private insurers from denying coverage or charging higher premiums based on preexisting conditions.

B. The Affordable Care Act Also Creates A Framework For Addressing Disparities In Minority Access To Quality, Appropriate, And Affordable Health Care.

In addition to the broad reforms discussed above, which will provide immediate health insurance and health care benefits to all Americans and will alleviate burdens created by the current health care system, the Affordable Care Act contains many reforms that target specific problems that minorities face. Many of these reforms are based on the Health Equity and Accountability Act of 2009 (the "Health Equity Act"). H.R. 3090, 111th Cong. (2009). The Health Equity Act was intended to "improve the health of minority individuals." *Id.*[3]

Congress specifically has found that racial and ethnic minority groups have poorer health status and more limited access to meaningful health care than other Americans. Congress therefore sought to "eliminate racial and ethnic health disparities," because it found that:

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[3] In September 2011, the Congressional Tri-Caucus introduced the Health Equity and Accountability Act of 2011, H.R. 2954, which builds upon the foundation created by the Affordable Care Act. *See Thank You Letter From Community Groups*, APIAHF, 1 (2011), http://www.apiahf.org/sites/default/files/HEAA%20of%202011%20Thank%20you%20Letter%20from%20Community%20Groups.pdf.

> (1) The health status of the American populace is declining and the United States currently ranks below most industrialized nations in health status measured by longevity, sickness, and mortality;
>
> (2) Racial and ethnic minority populations tend [to] have the poorest health status and face substantial cultural, social, and economic barriers to obtaining quality health care; and
>
> (3) Efforts to improve minority health have been limited by inadequate resources (funding, staffing and stewardship) and accountability.

Id. § 411(a).

The Affordable Care Act mirrors sections of the Health Equity Act, including provisions related to: (1) culturally and linguistically appropriate health care; (2) health workforce diversity; (3) data collection and reporting; and (4) programs and evaluation related to minority health. These portions of the Affordable Care Act seek to remedy racial and ethnic disparities in health care by creating a framework that specifically targets the needs of underserved minority communities. The provisions of this framework are unconnected to, and have gone into effect before, the minimum coverage provision. They accordingly are "fully operative as law." *See Regan*, 468 U.S. at 653. It is clear that Congress did not intend these crucial needs to go unmet in the absence of the minimum coverage provision, as Congress chose to implement these provisions years in advance of the minimum coverage provision.

1. The Affordable Care Act Improves Culturally And Linguistically Appropriate Health Care.

In drafting the Health Equity Act, Congress found that "[r]esearch establishes that the lack of language services creates barriers to and diminishes the quality of health care and health status for limited English proficient individuals." H.R. 3090 § 101(a)(2). Congress also found that, as the number of individuals with limited proficiency in English grows, there is a societal "responsibility to fund language services in the provision of health care and health care-related services." *Id.* § 101(a)(4).

Access to culturally and linguistically appropriate services and providers is imperative for Asian Americans, Native Hawaiians, and Pacific Islanders. Over 33% of Asian Americans have limited English proficiency, and 25% of Asian American households are without a member who is proficient in English. *Health Inequities in the Asian American Community*, Asian Am. Justice Center, 1, http://www.advancingequality.org/attachments/wysiwyg/1/AAJC_Health_Disparities.pdf. Although many Asian Americans, Native Hawaiians, and Pacific Islanders have chronic conditions, 94% of immigrants from Vietnam, Laos, and Cambodia "reported having no knowledge of blood pressure and its significance, and 85 percent reported no knowledge of how to prevent heart disease." *Id.* Similarly, although the Asian American, Native Hawaiian, and Pacific Islander communities had the "highest percentage increase in HIV infection and AIDS cases among racial and ethnic groups," members of these communities "were twice as likely as non-Hispanic whites to report knowing nothing about AIDS." *Id.* Linguistically and culturally appropriate services will help Asian Americans, Native Hawaiians, and Pacific Islanders understand the diseases that they have or are at risk for, and will help them avoid contracting these diseases.

"Sheela" demonstrates the dire consequences of health care that is not culturally and linguistically appropriate. Sheela suffered from severe Post-Traumatic Stress Syndrome ("PTSD") as a result of severe physical and mental domestic abuse. Because Sheela had limited English proficiency, she was unable to communicate with her health care providers. A miscommunication caused a psychiatrist to diagnose her as a paranoid schizophrenic. Following that misdiagnosis, Child Protective Services took Sheela's children. Sheela spent the next seventeen months attempting to regain custody of her children. Eventually, Sheela sought the counsel of Arizona South Asians For Safe Families ("ASAFSF"), which provided her with language access and support. Through an ASAFSF translator, a psychiatrist treated Sheela and found that she was neither psychotic nor schizophrenic. In the psychiatrist's professional opinion, Sheela was quite capable of taking care of her children. Eventually, Sheela was reunited with her children and received the treatment she needed. *See* Statement on file with ASAFSF.

Linguistic and cultural barriers to health care plague multiple subgroups of Asian Americans, Native Hawaiians, and Pacific Islanders. For example, Jane Ka'ala Pang, a registered nurse and program manager from Santa Ana, California, described the difficulties faced by an elder in the Marshallese community who attempted to access medical services. The elder, who had been an active leader in the Marshallese community for over 25 years, suffered from end stage renal failure, diabetes, and blindness. But because her local medical facility did not have a Marshallese translator on staff, she was unable to give informed consent or receive critical medical information. *See Stories From Our Communities: Jane Ka'ala Pang, RN, PHN*, APIAHF, http://www.apiahf.org/jane-kaala-pang-rn-phn (last visited Feb. 14, 2012).

Consequences of such failures are dire for these individuals and their families.

To address the issue of lack of culturally and linguistically appropriate health care, the Affordable Care Act requires and funds training for health care workers to learn to provide such care. For example, the Affordable Care Act establishes Primary Care Extension Programs that aim, in part, to train workers who "provide guidance to patients in culturally and linguistically appropriate ways." 42 U.S.C. § 280g-12 (2010). The Act also provides grants for culturally appropriate training for health care providers. *See id.* § 293e.

The Affordable Care Act also requires group health plans and group and individual health insurers to establish a culturally and linguistically appropriate appeals process for claims and coverage decisions. *Id.* § 300gg-19. Plans and providers are required to supply enrollees with culturally and linguistically appropriate notice of the appeals process and notify them of any public assistance that is available to help enrollees utilize the appeals process. *Id.*

2. The Affordable Care Act Seeks To Develop A Diversity-Sensitive Health Care Workforce.

Title V of the Affordable Care Act, entitled "Health Care Workforce," seeks "to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations." Pub. L. No. 111-148, § 5001, 124 Stat. 588 (2010). The Act focuses on researching, assembling, and evaluating data on the current state of the health care workforce and identifying aspects that need to be changed to meet the health care needs of the changing nation. 42 U.S.C. § 294q. It also focuses on supporting the health care workforce, improving health care workforce education and training, and enlarging the qualified health care workforce to expand "access to and delivery of health care services for all individuals." *Id.* In addition, the Affordable Care Act uses grants to encourage health care workforce diversity and to serve minority populations. For instance, the Act offers grants to support community health workers "to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations." *Id.* § 280g-11. The Affordable Care Act also prioritizes grants or contracts for medical schools that "have a record of training individuals who are from underrepresented minority groups." *Id.* § 293k. It funds development and operation of nurse-managed health clinics that are associated with a school or qualified health center or agency and "provide[] primary care or wellness services to underserved or vulnerable populations." *Id.* § 254c-1a. Like the Health Equity Act, Title V of the Affordable Care Act focuses on developing and evaluating research and projects that will train a health care workforce to be culturally competent and reduce health disparities. *Id.* § 294q.

Potri Ranka Manis, a registered nurse and Community Health Worker Trainer at Kalusugan Coalition, a health advocacy and outreach non-profit dedicated to improving the health of the Filipino American community, has witnessed the obstacles posed by lack of diversity in the health workforce. She reports that the Affordable Care Act already has benefited her organization in this regard. As a result of the Act's emphasis on improving the health workforce, Ms. Manis's organization has received additional federal funding to support its community outreach workforce. *See Stories From Our Communities: Potri Ranka Manis*, APIAHF, http://www.apiahf.org/potri-ranka-manis (last visited Feb. 14, 2012).

3. The Affordable Care Act Focuses On Understanding And Remedying Health Disparities Through Data Collection And Analysis.

For decades, medical scientists have treated Asian Americans, Native Hawaiians, and Pacific Islanders as one homogeneous group when studying serious medical conditions, leading to false conclusions about the incidence of diseases that do not take into account health disparities among different subgroups. For example, doctors have long considered all Asian women to have a lower risk of breast cancer because, in the aggregate, Asian women are diagnosed at a significantly lower rate than women of other ethnicities. *See* Scarlett Lin Gomez et al., *Hidden Breast Cancer Disparities in Asian Women: Disaggregating Incidence Rates by Ethnicity and Migrant Status*, 100 Am. J. Pub. Health S125, S130 (2010). Disaggregated data, however, reveal that United States-born Chinese and Filipina women under the age of fifty-five have higher rates of breast cancer than white women. *Id.* at S127-28. The medical community's failure to disaggregate health care data has left many individuals without proper attention. *Health Care Quality*, APIAHF, http://www.apiahf.org/policy-and-advocacy/focus-areas/health-care-quality (last visited Jan. 26, 2012).

The experience of Susan Matsuko Shinagawa, a fifty-four-year-old Japanese American woman in Spring Valley, California, illustrates one of the risks of aggregating data about the health care and status of the Asian American, Native Hawaiian, and Pacific Islander communities:

> I was denied a biopsy for a prominent and painful breast lump by a surgical oncologist who admonished me that, "Asian women don't get breast cancer." After seeking a second opinion and undergoing a surgical biopsy, I was eventually diagnosed with infiltrating breast cancer at the age of 34, and underwent a modified radical mastectomy, followed by combination chemotherapy. Ten years later, routine mammography revealed an unrelated breast cancer in my left breast, for which I underwent a second mastectomy. I have been advocating for better minority health data for the 20 years since my first breast cancer diagnosis. Yet, I continue to meet (primarily young) [Asian American, Native Hawaiian, and Pacific Islander] women diagnosed with breast cancer who were initially told by their health care providers that "Asian women don't get breast cancer."

Stories From Our Communities: Susan Matsuko Shinagawa, APIAHF, http://www.apiahf.org/node/143 (last visited Feb. 14, 2012).

In passing the Affordable Care Act, Congress recognized the need to correct the problems resulting from inappropriate aggregation of health care data. The Affordable Care Act, like the Health Equity Act, seeks to identify and reduce health care disparities by requiring federally funded or supported health care programs to collect and analyze health-related data according to "race, ethnicity, sex, primary language," and any other demographic information on health disparities that reasonably can be collected. 42 U.S.C. § 300kk (2010). This data will be available to both the government and researchers and will be used to identify and track health disparities. *Id.* This provision of the Affordable Care Act applies to Medicare providers, Medicaid, the Children's Health Insurance Program, and population surveys, among other public programs. *See id.*; Joel S. Weissman & Romana Hasnain-Wynia, *Advancing Health Care Equity Through Improved Data Collection*, 364 New Eng. J. Med. 2276, 2276 (2011).

Further, the Affordable Care Act requires the Department of Health and Human Services ("HHS") to issue new data collection standards. These new standards, released on October 31, 2011, add seven Asian subgroups (Chinese, Filipino, Asian Indian, Vietnamese, Japanese, Korean, and other Asian) and four Native Hawaiian and Pacific Islander subgroups (Native Hawaiian, Guamanian or Chamorro, Samoan, and other Pacific Islander) to federally-funded or -supported health care programs' data collection. As HHS Secretary Kathleen Sebelius has explained, improvements in data collection will enable HHS to "get a better understanding of why disparities occur and how to eliminate them. Improving the breadth and quality of our data collection and analysis on key areas, like race [and] ethnicity . . . is critical to better understanding who we are serving." Press Release, HHS, *HHS Announces Refined Survey Standards to Examine and Help Eliminate Differences in Care Based on Race, Ethnicity, Sex, Primary Language, or Disability* (Oct. 31, 2011), http://www.hhs.gov/news/press/2011pres/10/20111031b.html. Consistent data standards, as required by the Act, "will help identify the significant health differences that often exist between and within ethnic groups, particularly among Asian, Hispanic/Latino and Pacific Islander populations." *Id.*

4. The Affordable Care Act Includes Programs And Evaluations Related to Minority Health.

To address further the need for regulations focused on improving access to health care for minorities, the Affordable Care Act requires that Congress and other federal agencies develop programs to advance minority health.

First, the Affordable Care Act transfers the current Office of Minority Health to the Office of the Secretary of HHS, and charges that office with "improving minority health and the quality of health care minorities receive, and eliminating racial and ethnic disparities." 42 U.S.C. § 300u-6 (2010). The office must work towards this goal by awarding grants and contracts and by working with other agencies and outside entities to:

> assure improved health status of racial and ethnic minorities, and . . . develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. Such measures shall evaluate community outreach activities, language services, workforce cultural competence, and other areas as determined by the Secretary.

Id.

Second, the Affordable Care Act requires the heads of six federal health agencies to establish within their agencies an Office of Minority Health, headed by a director with minority health experience. *Id.* These agencies include the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

Third, the Affordable Care Act promotes the National Center on Minority Health and Health Disparities to an "Institute." This new Institute is charged with interagency coordination of research and activities related to minority health and health disparities. *Id.*

Finally, the Affordable Care Act requires regular reports to Congress on the status of these activities. *Id.* On March 23, 2011, the Secretary of HHS, through the Office of Minority Health, provided the first of such reports to Congress. The

Report explained that HHS representatives developed five goals for all of the offices of minority health and the National Institute on Minority Health and Health Disparities. *Report to Congress, supra*, at vi. These goals are:

> (1) to reduce disparities in population health;
>
> (2) to increase the availability of data to track and monitor progress in reducing disparities;
>
> (3) to reduce disparities in health insurance coverage and access to care;
>
> (4) to reduce disparities in the quality of healthcare; and
>
> (5) to increase health care workforce diversity and cultural competency.

Id.

* * *

Together, these provisions focus on the needs of minorities and create a framework through which Congress's goal of equalizing access to health care can be realized. Nothing suggests that it is "evident" that Congress would have foregone these efforts but for the minimum coverage provision. *See* Regan, 468 U.S. at 653.

III. CONCLUSION

As Congress intended, the Affordable Care Act will significantly improve access to quality health care for all Americans, including Asian Americans, Native Hawaiians, and Pacific Islanders. It also will lessen the burdens on currently uninsured individuals. The minimum coverage provision is not essential to the manner in which the Affordable Care Act functions. The minimum coverage provision and the remainder of the Affordable Care Act are not sufficiently dependent on one another to overcome the presumption of severability. If the Court finds that the minimum coverage provision is unconstitutional, Congress surely would prefer that the Court sever the minimum coverage provision and leave the remainder of the Affordable Care Act intact, thus preserving Congress's intent to improve access to quality, appropriate, and affordable health care for minorities and underserved populations.

February 17, 2012

Respectfully submitted,

Mee Moua
Priscilla Huang
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM
1828 L. Street, N.W., Suite 802
Washington, DC 20036
(202) 466-7772

Mark A. Packman
Counsel of Record
Jonathan M. Cohen
Kami E. Quinn
Alyson A. Foster
Michelle A. Price
Jenna A. Hudson
GILBERT LLP
1100 New York Ave., N.W., Suite 700
Washington, DC 20005
(202) 772-2320
packmanm@gotofirm.com

APPENDIX A

Statements of Interest of Additional *Amici Curiae*

AIDS Services in Asian Communities

AIDS Services in Asian Communities ("ASIAC") is a non-profit 501(c)(3) community-based organization dedicated to assisting low income and limited English proficient individuals overcome cultural and linguistic barriers to healthcare and social services. Founded in 1995, ASIAC was organized in response to early indications that HIV/AIDS was spreading within Philadelphia's Asian and Pacific Islander communities. We support this brief because we believe the Affordable Care Act will improve health care access for those in Philadelphia, Pennsylvania living with HIV/AIDS.

Asian American Cancer Support Network

The Asian American Cancer Support Network works to provide an educational, supportive, and diverse network of resources for Asian Americans affected by cancer, particularly in the San Francisco Bay area. Asian American cancer survivors and patients stand to gain many benefits from the Affordable Care Act, including increased access to insurance coverage. Therefore, we join as *amici* to the case now before the Court.

Asian American Health Coalition – HOPE Clinic

The Asian American Health Coalition ("AAHC") of the Greater Houston area is a non-profit organization dedicated to improving the health of all Asian Americans in Houston by increasing access to health care and through population-specific health promotion and health education projects. AAHC was founded in 1994 and the Coalition has actively promoted health access, knowledge, and disease prevention activities and programs in the Greater Houston area. In 2002, in recognition of the significantly unmet medical needs of the residents of Southwest Houston, we established the HOPE clinic to provide culturally and linguistically appropriate primary health care services to all, but especially to underserved Asians with limited English proficiency. AAHC supports the Affordable Care Act because of its investments in community health centers and cultural and linguistically appropriate care.

Asian & Pacific Islander Coalition on HIV/AIDS, Inc.

Asian & Pacific Islander Coalition on HIV/AIDS, Inc. ("APICHA") advocates and provides a welcoming environment for underserved and vulnerable people, especially Asians and Pacific Islanders, the LGBT community, and individuals living with and affected by HIV/AIDS. APICHA strives to improve the health of Asian American and Pacific Islander communities and to increase access to comprehensive primary care, preventive health services, and mental health and supportive services. We are committed to providing culturally competent services that enhance quality of life. The Affordable Care Act provides important access and coverage to underserved and marginal communities and allows APICHA to continue our important and lifesaving work. It is our pursuit for a healthier quality of life that we participate in this *amicus* brief.

Asian & Pacific Islander National Cancer Survivors Network

The Asian & Pacific Islander National Cancer Survivors Network ("APINCSN") is a network of cancer survivors, their family members, health care providers, researchers, and community members and organizations who are concerned about the issue of cancer and survivorship in Asian American, Native Hawaiian, and Pacific Islander communities. APINCSN links Asian Americans, Native Hawaiians, and Pacific Islanders with critical resources, such as contact with other survivors, referrals to cancer support and survivorship services, and access to multi-lingual cancer materials. It also offers supportive and educational networking opportunities. We are supporting this brief because we see the potential benefits of the Affordable Care Act for Asian Americans, Native Hawaiians, and Pacific Islanders with cancer.

Asian & Pacific Islander Wellness Center

The Asian & Pacific Islander Wellness Center is a health services, education, research, and policy organization dedicated to educating, supporting, empowering, and advocating for Asian and Pacific Islander communities – particularly Asians and Pacific Islanders living with or at risk for HIV/AIDS. Based in San Francisco, California, the Asian & Pacific Islander Wellness Center was founded in 1987 as a grassroots response to the HIV/AIDS crisis in Asian and Pacific Islander communities. As the oldest non-profit HIV/AIDS services organization in North America targeting Asian and Pacific Islander communities, the Asian & Pacific Islander Wellness Center operates a free health center, provides HIV/AIDS care services, conducts education awareness and testing for HIV, and provides trainings and capacity building assistance. The Asian & Pacific Islander Wellness Center supports this brief because we believe the Affordable Care Act will improve health care access for Asian Americans and Pacific Islanders living with HIV/AIDS.

Asian Health Services

Asian Health Services is a community health center that offers primary care services to over 21,000 patients, with over 101,000 patient visits annually. Asian Health Services's mission is to serve and advocate for the medically underserved, including the immigrant and refugee Asian community, and to assure equal access to health care services regardless of income, insurance status, language, or culture. The Affordable Care Act will insure that more individuals will have the opportunity to get the care they need, when they need it, and increase Asian Health Services's capacity to further fulfill its mission. Our interest in the continued and increased care for our community leads us to participate in this *amicus* brief.

Asian Pacific AIDS Intervention Team Health Center

Asian Pacific AIDS Intervention Team ("APAIT") Health Center works to positively impact the quality of life for medically underserved communities living with or at risk for HIV/AIDS and other health disparities through culturally competent and linguistically appropriate programs in Southern California. Founded in 1987, APAIT Health Center has offices in Los Angeles County and Orange County, and operates several programs that aim to increase awareness of HIV/AIDS in Asian American and Pacific Islander communities. APAIT Health Center works to advocate, educate, and achieve optimal health and well-being for medically underserved communities. We join this brief in support of the Affordable Care Act because we believe full implementation will help improve the quality of life for medically underserved communities.

Asian Pacific American Network of Oregon

The Asian Pacific American Network of Oregon is a statewide grassroots organization, uniting Asians and Pacific Islanders to achieve social justice. We use our collective strengths to advance equity through empowering, organizing, and advocating within our communities. We envision a just and equitable world where Asians and Pacific Islanders are fully engaged in the social, economic, and political issues that affect them. We join this brief because the Affordable Care Act will help achieve our goal of improved health outcomes for all Oregonians, particularly through the application of new data collection standards and expanded health services that are culturally and linguistically appropriate.

Asian Pacific Community In Action

Asian Pacific Community in Action ("APCA") was created in 2002 to meet the health-related needs of Asian/Pacific Islander individuals and families residing in Maricopa County, Arizona. APCA provides access to preventive services such as Hepatitis B screening and vaccination, mammograms, diabetes testing, and tobacco prevention and cessation information, among many other advocacy and direct service programs. APCA recognizes the potential for improving the health and health care for our communities under the Affordable Care Act.

Asian Services In Action, Inc.

Asian Services In Action ("ASIA"), Inc. seeks to empower Asian Americans and Pacific Islanders in Northeastern Ohio to access high-quality, culturally and linguistically appropriate information and services. Founded in 1995, ASIA, Inc. is the only comprehensive Asian American and Pacific Islander health and social services agency in the region. Through its five program areas, ASIA, Inc. believes in a "no wrong door" approach to program service delivery through in-house staff or referral services, and similarly supports the Affordable Care Act's "no wrong door" approach to enrolling individuals for health care.

Asians and Pacific Islanders with Disabilities of California

Asians and Pacific Islanders with Disabilities of California ("APIDC") is a 501(c)(3) organization whose mission is to give a voice and a face to Asians and Pacific Islanders with physical and mental disabilities. Our goals are to help break down the service and cultural barriers faced by Asians and Pacific Islanders with disabilities; to provide Asians and Pacific Islanders with disabilities and their families with knowledge; and to create a community network for empowerment and independence. We support this *amicus* brief because the disabled community is an underserved population, and when it comes to Asians and Pacific Islanders with disabilities, we are an even more underserved population. By joining this brief, we are giving a voice and face to Asians and Pacific Islanders with disabilities who will be helped by the all important Affordable Care Act.

Center for Pan Asian Community Services, Inc.

Center for Pan Asian Community Services ("CPACS"), Inc. was founded in 1980 to create and deliver culturally and linguistically competent, comprehensive health and social services to counteract problems faced by immigrants, refugees, and racially-ethnic minorities. CPACS, Inc.

continues to focus on issues and concerns of Asian Americans, especially women, children, and families with low incomes through their many programs. The organization supports the Affordable Care Act because its provisions will help CPACS, Inc. continue to serve close to 2,500 individuals in the Atlanta area.

Coalition for Asian American Children and Families

Coalition for Asian American Children and Families ("CACF") believes that children of all backgrounds should have an equal opportunity to grow up healthy and safe, and should live in a society free from discrimination and prejudice. CACF advocates on behalf of underserved families in our community, especially immigrants struggling with poverty and limited English skills. CACF promotes better policies, funding, and services for East Asian, South Asian, Southeast Asian, and Pacific Islander children, youth, and families. We support the Affordable Care Act because it will help to achieve our goal to improve the health and well-being of Asian Pacific American children and families in New York City.

Council for Native Hawaiian Advancement

The Council for Native Hawaiian Advancement ("CNHA") is a national non-profit organization founded in 2001 to enhance the cultural, economic, and community development of Native Hawaiians. The CNHA mission is achieved through the administration of its Native Hawaiian Policy

Center, the operation of a certified community loan fund, delivery of capacity-building and leadership development services, and support of community-owned social enterprises. CNHA has over 150 member organizations in its network in Hawaii and the continental United States. We support this brief because we believe the Affordable Care Act improves health care access for Native Hawaiian communities.

Empowering Pacific Islander Communities

Empowering Pacific Islander Communities' mission is to mobilize Pacific Islander communities to foster culturally relevant opportunities for achieving social justice through advocacy, research, and development. We are committed to improving the health of our communities and welcome the advances made under the Affordable Care Act.

Filipino Community Cancer Collaborative

Filipino Community Cancer Collaborative ("FCCC") was established in 2005 by the American Cancer Society to empower the Filipino community living in the San Francisco Bay area through culturally responsive cancer-related education and outreach programs. In the state of California, among Asians subgroups, Filipinos have the highest mortality rates for female breast cancer, prostate cancer, and thyroid cancer. Therefore, FCCC's efforts have been directed to educate the community about these cancers and to promote prevention and screening. We look forward to the improved access to health insurance coverage for members of our community under the Affordable Care Act.

Guam Communications Network

The Guam Communications Network ("GCN") is a non-profit Chamorro community-based multi-service agency headquartered in Long Beach, California. Founded as a resource for stateside Chamorros and Guamanians to reach out to relatives on Guam after Typhoons Gay and Omar in 1992, GCN facilitates increased public awareness of the issues concerning the people, island, and culture of Guam through education, coalition-building, and advocacy. GCN serves Chamorro communities in Los Angeles, Orange, Riverside, San Diego, and San Bernardino Counties through cultural enrichment/social service programs in health and welfare, cancer research, senior care management, and other specific public health issues. To that end, we support this brief and the improvements the Affordable Care Act has made to our health care system.

Hawai'i Island HIV/AIDS Foundation

The Hawai'i Island HIV/AIDS Foundation, is a registered 501(c)(3) non-profit organization located in Hawaii. Founded in 2003, the Hawai'i Island HIV/AIDS Foundation is dedicated to assisting those affected by HIV/AIDS to maximize their quality of life and to ending the spread of HIV. We also utilize the lessons learned in the HIV epidemic to care and advocate for others in the fight against related diseases. We support this brief because we believe the Affordable Care Act will improve health care access for those in Hawaii living with HIV/AIDS.

Kalusugan Coalition

The Kalusugan Coalition is a multidisciplinary collaboration dedicated to creating a unified voice to improve the health of the Filipino American community in the New York/New Jersey area through network and resource development, educational activities, research, community action, and advocacy. As a result of the Coalition's goal of developing culturally and linguistically appropriate health education, services, and resources, and its commitment to mobilizing around health issues faced by Filipinos, we are interested in making health insurance accessible and affordable to Filipino Americans and improving the health care system in the United States.

Lao Assistance Center of Minnesota

The Lao Assistance Center of Minnesota's goals include meeting basic needs, increased self-reliance, youth development, reduced social isolation, and promoting cultural equity. Our five interconnected programs serve Lao families including at-risk, low, and moderate income households. Our key health programs focus primarily on substance abuse awareness and prevention, insurance expansion to children, Hepatitis B education, and breast cancer awareness. With the Affordable Care Act, the Lao Assistance Center of Minnesota will continue to provide assistance with health services that are culturally appropriate and ensure that there is adequate care in our community. It is our dedication to healthier lifestyles and access to care that we participate in this *amicus* brief supporting the Affordable Care Act.

Light and Salt Association

Light and Salt Association is a 501(c)(3) non-profit organization whose mission is to serve as a resource for the Chinese community in the Houston area in taking care of needy Houstonians, Chinese and non-Chinese alike. Light and Salt Association was founded in 1997 and operates several health programs, most notably their Cancer Support Network which provides culturally, linguistically, and spiritually competent support for needy individuals including cancer patients and their families, and families affected by intellectual and developmental disabilities. Light and Salt Association supports the Affordable Care Act because it invests in prevention initiatives.

Malama Pono Health Services

The missions of Malama Pono Health Services are to stop the spread of HIV/AIDS, STDs, and infectious Hepatitis on Kaua'i through education and to serve those persons infected with or affected by these diseases. Based in Lihue, Hawaii, Malama Pono Health Services operates a case management program, referral services, and a variety of specialized, culturally appropriate HIV education programs for the community. We are guided by a vision of honoring and preserving the love of family and community and meeting the challenges of today and the future. We believe the Affordable Care Act supports these interests, and therefore join this brief.

Mary Queen of Viet Nam Community Development Corporation, Inc.

Mary Queen of Viet Nam Community Development Corporation, Inc. ("MQVN") was established by community leaders in May 2006 to assist Vietnamese Americans in New Orleans East rebuild their lives and their community after Hurricane Katrina. Together with community partners, MQVN's work encompasses health care, environmental and agricultural concerns, education, housing, social services, economic development, and culture and the arts. Consequently, we have a strong interest in securing access to health insurance and health care for Vietnamese Americans living in Louisiana.

National Tongan American Society

The National Tongan American Society ("NTAS") is a national non-profit organization that advocates and empowers all Tongan Americans and other Pacific Islanders through programs and referrals that promote health, youth development, model citizenship, education, and cultural preservation. Founded in 1995, NTAS is based in Salt Lake City, Utah. NTAS has several programs that promote the well-being and health of Tongan Americans and other Pacific Islanders. NTAS educates and mobilizes Pacific Islanders at a grassroots level to improve their personal and community health. NTAS supports this brief.

Native Hawaiian and Pacific Islander Alliance

The Native Hawaiian and Pacific Islander Alliance ("NHPIA") is a national non-profit organization that generates a broad base of public and private support for the further development and implementation of a Native Hawaiian and Pacific Islander health agenda. Based in Southern California, the NHPIA has worked to convene national stakeholder meetings in Washington, DC, and around California to determine strategies to advance its goals of advocacy, data collection, resources management, and workforce. Consequently, we support this brief and full implementation of the Affordable Care Act.

New Mexico Asian Family Center

The New Mexico Asian Family Center is a place for Asian immigrants and their families to share their concerns, learn about their own and others' cultures, build supportive networks, and increase self-sufficiency. We envision a world where inclusiveness is valued and equal opportunity and justice exist for all, including equal access to health insurance and health care. As a result, we support the advances made under the Affordable Care Act presently before the Court.

Orange County Asian and Pacific Islander Community Alliance, Inc.

Orange County Asian and Pacific Islander Community Alliance, Inc. ("OCAPICA") was founded on a mission to build a healthier and stronger community by enhancing the well-being of Asians and Pacific Islanders through inclusive partnerships in the areas of service, education, advocacy, organizing, and research. OCAPICA was established 1997 as a coalition-type organization that would bring together various community organizations and partners to address the needs of low income Asian and Pacific Islander communities in Orange County. We support the Affordable Care Act because it will make a difference for the communities we serve.

Pacific Islands Primary Care Association

The Pacific Islands Primary Care Association ("PIPCA") promotes and supports quality primary health care in the United States-affiliated Pacific Island jurisdictions – American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and Republic of Palau. With its office in Hawaii, PIPCA works in support of the expansion and strengthening of primary care services; advocating for the expansion and improvement of integrated systems of care; building and sustaining local and regional capacity; and supporting strong collaboration throughout the region. In that the Affordable Care Act will greatly improve access to quality, appropriate, and affordable health care, PIPCA, in keeping with its mission, supports and joins the APIAHF as *amici curiae*.

Project CHARGE

Project CHARGE (Coalition for Health Access to Reach Greater Equity) seeks to increase financial access to healthcare for Asian and Pacific Islander children and families in New York City. Project CHARGE advocates for increasing access to public and employer-based health insurance coverage, and for increasing affordability of care, including prescription medication and specialty services. We look forward to advancing both of these goals under the Affordable Care Act presently before the Court.

Saath USA

Saath USA's mission is to improve the health of South Asians (Asian Indians, Pakistanis, Bangladeshis, Sri Lankans, and Nepali) in Southern California through the use of effective health programs implemented in faith and other community settings. This mission is accomplished through collaboration with universities to conduct research involving South Asians, and through community experts trained to provide culturally-sensitive health education to South Asians. We are based in Los Angeles and support this brief because we believe full implementation of the Affordable Care Act will help improve the quality of life for South Asians in Southern California.

Samoan Community Development Center

The Samoan Community Development Center ("SCDC") was founded in 1991 by a group of highly respected members of the Samoan community in the San Francisco Bay area in response to issues facing the local Samoan community. The SCDC is the only Samoan and Pacific Islander community-based organization in San Francisco providing services that are culturally sensitive and linguistically appropriate to lower income and disadvantaged families and individuals. The continued efficient care for the Samoan and Pacific Islander Community by the SCDC depends on the successful implementation of many provisions found in the Affordable Care Act. SCDC's interest in cultivating a community of healthy, happy, and empowered people has resulted in our participation in this *amicus* brief.

Samoan National Nurses Association

The Samoan National Nurses Association ("SNNA") was established in 2000 as a non-profit organization to assist the Samoan community and other Pacific Islanders to better health. SNNA works to improve the community's opportunities through quality health education, prevention screenings and primary health services, local and national policy advocacy, community organizing, and community-based research. As an association of care providers and advocates, SNNA recognizes the potential benefits to the health of Samoans and other Pacific Islanders under the Affordable Care Act.

Taulama For Tongans

Taulama For Tongans ("Taulama") is a non-profit, community-based organization serving Tongans in San Mateo County, California, with available health resources. Taulama seeks to educate the greater

Tongan community through linguistically and culturally relevant outreach, specifically by providing educational materials and community events on cancer, Hepatitis, and other chronic diseases. With greater access to health care through the Affordable Care Act, Taulama educates the community on how to be healthy and stay healthy by understanding what health care services are available. Our interest in the continued and increased care for our communities leads us to participate in this *amicus* brief.

TOFA Inc.

TOFA stands for *To'utupu'o e 'Otu Felenite Association*, which translates to "Friendly Islands Youth." TOFA officially launched as a 501(c)(3) non-profit organization in 2000, and started as a way to provide needed support for the growing number of Pacific Islanders in the Sacramento area. The mission of TOFA is to preserve and enhance the overall health and wellness of the Pacific Islander community in the Greater Sacramento area by providing resources that support and promote higher education, community leadership opportunities, civil rights awareness, and cultural arts. Our interest in the health and productivity of our community has resulted in our participation in this *amicus* brief.

Tongan Community Service Center

The Tongan Community Service Center ("TCSC") is a program of Special Service for Groups ("SSG"). SSG is a Los Angeles based non-profit organization that provides community-based solutions, encouraging community involvement and self-sufficiency, to the social and economic issues facing those in greatest need. SSG serves as a bridge between people with common needs across traditional ethnic, racial, and other cultural boundaries to identify ways to pool resources. SSG does so by developing and managing programs which serve our many communities. The TCSC serves the Tongan communities of Southern California with health education, case management, patient navigation, health resources, and understanding health assessments and data. Our core belief that everyone deserves access to affordable, comprehensive care leads us to participate in this *amicus* brief.

Vietnamese American Young Leaders Association of New Orleans

The Vietnamese American Young Leaders Association of New Orleans ("VAYLA-NO") is a youth-led community-based organization that empowers Vietnamese American and underrepresented youth through supportive services focused on cultural enrichment and positive social change. Located in New Orleans, VAYLA-NO envisions a world where young people have the academic foundation, leadership skills, and opportunities to affect change for a vibrant and thriving community. We support this brief because the Affordable Care Act allows children to remain on their parents' insurance until age twenty-six.

WAPI Community Services

WAPI Community Services provides and advocates for culturally competent and age-appropriate prevention and substance abuse treatment services for Asian Pacific Islander youth and all youth of color in King County, Washington. WAPI recognizes that our vision of creating an environment for children, youth, adults, families and communities that is healthy and substance abuse free will be one step closer with the advances of the Affordable Care Act. We therefore join as *amici*.

West Michigan Asian American Association

West Michigan Asian American Association is a Michigan non-profit organization that seeks to build a collaborative, active, and committed Asian American community in West Michigan with a focus on health care, education, and empowerment. We support this *amicus* brief because the enactment of the Patient Protection and Affordable Care Act on March 23, 2010 set the foundation for historic changes to our country's health care system. These changes address many of the inefficiencies and dysfunctions of the current health care system and help to end some of the worst abuses of the insurance industry.

AMICUS
CURIAE
BRIEF

No. 11-400

IN THE
Supreme Court of the United States

FLORIDA, ET AL.,
Petitioners,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVS., ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS and INDIVIDUAL PHYSICIANS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

(MEDICAID ISSUE)

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608
aschlafly@aol.com

DAVID P. FELSHER
Counsel of Record
488 MADISON AVE.
NEW YORK, NY 10022
(212) 308-8505
dflaw@earthlink.net

Counsel for Amici

QUESTION PRESENTED

Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress' spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?

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No. 11-400/MEDICAID ISSUE

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INTERESTS OF *AMICI CURIAE*[1]

Amici curiae ("*Amici*") are individual physicians and a national association of physicians. *Amici* file this brief to assist the Court in defining and resolving the Medicaid Expansion issue, one of four issues for which this Court has directed the parties, and any interested *amicus curiae*, to brief. Order dated, December 8, 2011 ("Briefing Order").[2]

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[1] This brief is filed with the written consent of all parties. Those consents are filed with the Clerk of this Court. Pursuant to Sup. Ct. Rule 37.6, counsel for *Amici Curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *Amici*, members of *Amici*, or *Amici*'s counsel make a monetary contribution to the preparation or submission of this brief.

[2] The Court has also directed briefing regarding the following issues: (1) the constitutionality of the individual mandate; (2) the applicability of the Anti-Injunction Act; and (3) severability.

Since 1943, *Amicus* The Association of American Physicians and Surgeons, Inc. ("AAPS") has been dedicated to the highest ethical standards of the Oath of Hippocrates and to preserving the sanctity of the patient-physician relationship. AAPS has filed numerous *amicus curiae* briefs in noteworthy cases like this one. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 933 (2000) (citing an AAPS *amicus* brief). Because AAPS has also commenced an action against several Respondents which contains overlapping allegations of unconstitutionality, the disposition of this Petition may affect the rights of AAPS and its members. *Association of American Physicians and Surgeons, Inc. v. Sebelius*, Case No. 1:10-cv-0499-ABJ (D.D.C.).

Amicus Leah S. McCormack, M.D., privately practices dermatology in New York City, New York. She earned certification from the American Board of Dermatology and is a fellow of the American Academy of Dermatology. She is the immediate Past-President of the Medical Society of the State of New York.

Amicus Guenter L. Spanknebel, M.D., privately practiced gastroenterology. He is a Past-President of the Massachusetts Medical Society and is currently chair of its History Committee. He has served as a Trustee of the Health Foundation of Central Massachusetts and on the faculties of the medical schools at Tufts University and the University of Massachusetts.

Amicus Janis Chester, M.D., privately practices psychiatry in Delaware, serves as chair of the

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Briefing Order. On January 6, 2012, *Amici* filed a brief in support of Petitioners regarding severability ("Severability Brief").

Department of Psychiatry at a community hospital, is a member of the faculty at Jefferson Medical College and holds a variety of positions with organized medicine and psychiatry, locally and nationally.

Amicus Mark J. Hauser, M.D., privately practices psychiatry and forensic psychiatry in Massachusetts and Connecticut.

Amicus Graham Spruiell, M.D., privately practices forensic psychiatry and psychoanalysis in the Boston area.

Amici have followed attempts in recent years to enact health care reform legislation. As active members of the medical profession and pursuant to their ethical obligations, *Amici* have monitored the introduction, passage and early implementation of the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010) ("ACA"), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010) ("HCERA" or "Reconciliation Act").

For the reasons set forth below, *Amici* believe that the Medicaid Expansion Provisions of ACA ("MXPs") do not fall within the scope of congressional powers enumerated in the Constitution. As explained in *Amici's* Severability Brief, should the Court find the MXPs unconstitutional, ACA should be declared unconstitutional in its entirety.

In addition, *Amici* respectfully ask the Court to reconsider its approach to analyzing federally compelled state spending. This brief is submitted to provide the Court with greater clarity on that issue.

ARGUMENT

I. THE MEDICAID EXPANSION PROVISIONS UNCONSTITUTIONALLY BURDEN STATES' FINANCES, VIOLATE THE GUARANTEE OF A REPUBLICAN FORM OF GOVERNMENT FOR THE STATES, AND BREACH THE FIDUCIARY DUTY OWED BY THE FEDERAL GOVERNMENT TO THE STATES

It is axiomatic that our "Nation cannot plunder its own treasury without putting its Constitution and its survival in peril." *Clinton v. City of New York*, 524 U.S. 417, 449 (1998) (Kennedy, J., concurring). One corollary to this principle is that our Nation cannot plunder the treasuries of its political subdivisions, *i.e.* the States, without putting the existence of the States in jeopardy. The Constitution explicitly recognizes the continued vitality of the individual States. Not only does the term "State" appear in every Article of the Constitution and a majority of the Amendments to the Constitution, but the continued existence of each State as an independent and vibrant republic is virtually assured by the Guarantee Clause,[3] U.S. CONST. art. IV, sec. 4, and the supermajority requirement to amend the Constitution, U.S. CONST. art. V.

The strings attached to the Medicaid Expansion Provisions of ACA are onerous. Each State will have to spend considerably more money to fund Medicaid to prevent it from losing its federal Medicaid grant completely. Such a Hobson's choice is no choice at all. Regardless of the choice each State makes, that State's spending will increase. As a State's spending increases, either its taxes or its debt or both must increase. In any case, the burden is on the taxpayers of that State to pay for those increases without the affirmative decision of the State's Legislature and Governor. State spending is to be increased by a federal fiat. This is the very antithesis of a republican form of government and is, therefore, prohibited by the Constitution. Examined in this light, the MXPs are not merely pre-conditions to the disbursement of funds but rather an assault on the sovereignty of the States and the rights of their citizens - as state citizens.

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[3] In *New York v. United States*, 505 U.S. 144, 183-86 (1992), Justice O'Connor suggested that the Guarantee Clause did not always present a non-justiciable political question. Because ACA threatens the States' fiscal viability, this case presents a justiciable controversy.

This argument is all the more powerful if the Court considers that the mandate to increase Medicaid spending will further deteriorate the already precarious financial condition of many States. *See* United States Government Accountability Office,[4] *STATE AND LOCAL GOVERNMENTS: Fiscal Pressures Could Have Implications for Future Delivery of Intergovernmental Programs*, GAO Report No. 10-899 (July 2010) ("*GAO Report 10-899*"). According to the GAO, the "primary driver of the fiscal pressure confronting the state and local sector is the continued growth in health-related costs. State and local expenditures on Medicaid and the cost of health insurance for state and local retirees are expected to grow more than GDP." *Id*. at 7.

The GAO has also reported that state and local governments face considerable additional fiscal pressure from pensions offered to their employees. *Id.* at 30. Only a few days ago, Senator Hatch, the Ranking Member of the Senate Committee on Finance, reported that the aggregate underfunding of state and local defined benefit pension plans may exceed $4 trillion.[5] United States Senate Committee on Finance, *State and Local Government Defined Benefit Pension Plans: The Pension Debt Crisis that Threatens America*, 112th Cong., 2d Sess. (January 2012) ("*Hatch Report*"). He said: "[t]he potential effect of state and municipal pension debt on state insolvency or default is significant, and such an event is a possible contagion that could infect even responsible jurisdictions." *Id.* at 3.

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[4] Hereinafter "GAO".

Considering that many view Medicaid as a federal-state partnership, *GAO Report 10-899* at 28-29, it is not unreasonable for this Court to examine the MXPs in that light. The GAO explained:

> Given the nature of the partnership among levels of government in providing services to the public and the economic interrelationships among levels of government, understanding patterns in state and local government expenditures and revenues is crucial for identifying and analyzing potential fiscal pressures for the sector. ***The federal government partners with state and local governments to achieve national priorities through implementation of a variety of programs. Such programs range from Medicaid***, a joint federal-state program that finances health care for certain categories of

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[5] This number exceeds the aggregate municipal bond debt of $2.9 trillion. *Hatch Report* at 1.

> low-income individuals, to disaster recovery, ... The interconnectedness which defines intergovernmental programs requires that all levels of government remain aware of and ready to respond to fiscal pressures.

Id. at 28-29 (emphasis added).

Assuming *arguendo* that the Court adopts such a partnership theory, it becomes clear that the federal government breached its fiduciary duties to its partners for the following reasons: (1) by imposing onerous conditions on its partners, *i.e.* the states; Brief of State Petitioners on Medicaid 7-13 in *States of Florida et al. v. United States Dept. of Health and Human Services et al.* (Docket No. 11-400) (Jan. 10, 2012); (2) by failing to obtain an unqualified opinion from the federal government's own financial auditors, GAO, *Press Release: Significant Financial Management and Fiscal Challenges Reflected in the U.S. Government's 2011 Financial Report* 1 (Dec. 23, 2011) (hereinafter "*GAO Press Release*") ("The [GAO] cannot render an opinion on the 2011 consolidated financial statements of the federal government, because of widespread material internal control weaknesses, significant uncertainties, and other limitations.");[6] and (3) by failing to consider that, under the Constitution, Congress lacks authority to spend beyond the end of its own term. *See* Point III, *infra.*

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[6] In addition to receiving a qualified opinion, both the Comptroller General and the Secretary of the Treasury acknowledged the long-term fiscal pressures upon the federal government. Comptroller General Dodaro stated: "The comprehensive fiscal projections presented in the 2011 *Financial Report* show that – absent policy changes – the federal government continues to face an unsustainable long-term fiscal path." *GAO Press Release* at 2. In a cover letter to the 2011 *Financial Report of the United States Government* (hereinafter "*2011 Financial Report*"), Secretary Geithner also acknowledged the federal fiscal condition. He

II. THE TEXT, STRUCTURE AND HISTORY OF ARTICLE I, SECTION 8 CONFIRM THAT THE PHRASE "PROVIDE FOR THE ... GENERAL WELFARE" IS A LIMITATION ON THE TAXING POWER AND NOT THE SOURCE OF AN INDEPENDENT POWER TO SPEND

In revisiting *South Dakota v. Dole*, 483 U.S. 203 (1987), the Court might consider that the text, structure, spirit and history of the Constitution indicate that the "power to spend" is not an enumerated power of Congress, but rather a

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stated: "This report provides another sobering picture of our long-term fiscal challenges. Our actual and projected deficits are too high ...." *Id. See also* Peter G. Peterson, ***Running on Empty*** (2004). Former Secretary of Commerce Peterson addressed our fiscal problems both morally and philosophically. He said: "I thought the philosophical issue was whether a modern, media-driven democracy that focuses on immediate crises could respond effectively to a very different kind of threat – a silent, slow-motion, long-term crisis like entitlements." *Id.* at xxiii. Secretary Peterson also considered it immoral to pass huge debts on to our children. In economic terms, he explained,

> When [structural] deficits are incurred in order to fund a rising transfer of resources from young to old, they also constitute an injustice against future generations.
>
> Economically, the problem with deficits is that they absorb national savings and crowd out productive investments ...
>
> A century ago, America's net national savings rate was the highest in the developed world. Fifty years ago, it was somewhere in the middle. Today it is the lowest.

Id. at 40, 44.

constraint or condition upon the power of Congress to raise revenues.

We begin with the text of the Constitution. Article I, Section 8, Clause 1 provides: "The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and ***provide for the*** common Defence and ***general Welfare*** of the United States; but all Duties, Imposts and Excises, shall be uniform throughout the United States ...." U.S. CONST. art. I, sec. 8, cl. 1 ("Revenue Clause") (emphasis added). Whether called the "Spending Clause" or the "General Welfare Clause," the alleged source of congressional authority is the highlighted language above. Its appellation is irrelevant.

To begin with, the Constitution does not once use the word "spend" or "spending".

Second, each of the powers enumerated in Article I, Section 8 begins with the capitalization of the word "To".[7] That means, a capitalized "To" signals the enumerated power. Indeed, nowhere else in the remainder of the Constitution is the word "to" capitalized.

Third, only a semicolon separates the powers enumerated in Article I, Section 8. U.S. CONST. art. I, sec. 8. *See* The Federalist, No. 41, 263 (Madison) (Clinton Rossiter, ed. 1961).

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[7] Each of the eighteen clauses enumerating the powers of Congress also has the same grammatical structure. They begin with the infinitive form of an action verb followed by an object of that action verb. *See e.g.* U.S. CONST. art. I, sec. 8, cl. 9 ("To constitute Tribunals inferior to the [S]upreme Court") (The verb is "To constitute." The object of that verb is "Tribunals inferior to the Supreme Court").

Fourth, because the powers enumerated in Article I, Section 8, form a single sentence, Congress is limited to those lawmaking powers.[8]

Fifth, the language "to ... provide for the ... general Welfare" and the placement of that language after the language "To lay and collect Taxes, Duties, Imposts and Excises" is indicative of a limitation on the allowable purposes for the exercise of congressional power to raise revenue. To argue otherwise would mean: (1) that the ends would justify means outside of the enumerated powers; and (2) that the remainder of the enumerated powers are superfluous.

Sixth, where more than one action verb was used to define an enumerated power within a single clause of article I, section 8, the Framers found it unnecessary to insert a second "To" or "to" before such additional action verb. *See e.g.*, U.S. CONST. art. I, sec. 8, cl. 13 ("***To provide and maintain*** a Navy") (emphasis added). Thus, a single use of the word "To" was distributed to each enumerated power within a single clause. In clause 1, however, a second "to" was used without being capitalized. That second "to" appears to be distributed over the phrases: "***pay*** the Debts," U.S. CONST. art. I, sec. 8, cl. 1 (emphasis added), "***provide*** for the common Defence," *id.* (emphasis added), and "***provide*** for the ... general Welfare." *Id.* (emphasis added). Therefore, if the language "general Welfare" is the source of the so-called congressional "spending power" then the language "pay the Debts" and "provide for the common Defence" would also provide independent sources of congressional power. However, those phrases do not establish other congressional powers because those phrases would clearly make numerous other provisions of the Constitution superfluous.

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[8] Congress has other non-lawmaking powers including, but not limited to the following: (1) the power of the House of Representatives to impeach, U.S. CONST. art. I, sec. 2, cl. 5; (2) the power of the Senate to try impeachments, U.S. CONST. art. I, sec. 3, cl. 6; (3) the power of each chamber to make its own rules of proceeding, U.S. CONST. art. I, sec. 5, cl. 2; (4) the power of the Senate to ratify treaties, U.S. CONST. art. II, sec. 2, cl. 2; (5) the power of the Senate to confirm ambassadors and members of this Court, U.S. CONST. art. II, sec. 2, cl. 2; and (6) the power to propose amendments to the Constitution, U.S. CONST. art. V.

With respect to the phrase "to pay the Debts," the second clause of Article I, section 8, separately gives Congress the power to borrow in the future, U.S. CONST. Art. I, sec. 8, cl. 2, and the first clause of Article VI assumes debts incurred prior to the ratification of the Constitution. U.S. CONST. art. VI, cl. 1. Furthermore, Section 4 of the Fourteenth Amendment covers debts incurred for the payment of bounties and pensions for services rendered in suppressing insurrection or rebellion against the United States. U.S. CONST. amend. XIV, sec. 4. With respect to the phrase "to ... provide for the common Defence," the lack of an independent power is more apparent. That phrase would render superfluous and possibly meaningless the eleventh through sixteenth Clauses of Article I, Section 8. U.S. CONST. art. I, sec. 8, cls. 11, 12, 13, 14, 15, and 16.

Finally, the word "general" explicitly qualifies the word "Welfare" and provides an additional limitation on any alleged "spending power." One commentator has pointed out: "Congress ... has only the power to spend for the 'general' welfare and not for the special welfare of particular regions or states, even if the spending was undertaken in all regions or all states and therefore might be said to enhance 'general' welfare in the aggregate." John C. Eastman, *Restoring the "General" to the General Welfare Clause*, 4 Chapman L. Rev. 63, 65 (2001) ("*Eastman*"). Professor Eastman explained:

> In order to understand fully the meaning that the framers attributed to this "general welfare" limitation, it is perhaps best to begin with the document from which the clause was derived. The "general welfare" language of Article I, Section 8 is drawn from two clauses in the Articles of Confederation that were commonly understood as imposing restrictions on the Confederation Congress.

Id. at 72. Specifically, Article III of the Articles of Confederation provided that the States "'entered into a firm league of friendship with each other, for their common defence, the security of their Liberties, and their mutual and *general welfare* ....'" *Id.* at 78 (quoting Articles of Confederation art. III, emphasis added by Professor Eastman). The eighth article of the Articles of Confederation similarly provided:

> "All charges of war and all other expenses, that shall be incurred for the common defence or general welfare, and allowed by the United States, in congress assembled, shall be defrayed out of a common treasury, which shall be supplied by the several states, in proportion to the value of all land within each State ...."

Eastman, 4 Chapman L. Rev. at 78 (quoting Articles of Confederation art. VIII, added emphasis omitted). Regarding the debate over the Constitution's ratification, James Madison later noted that "the language of Article I, Section 8 was drawn from these provisions of the Articles of Confederation, where it was never thought to give to the Confederation Congress a power to legislate in all cases whatsoever." *Eastman*, 4 Chapman L. Rev. at 78 (footnote and internal quotation marks omitted).

In construing the Revenue Clause and the phrase "to ... provide for the ... general Welfare" within the Revenue Clause, there is no better guide for this Court than James Madison, who authored many of the Federalist Papers. During a 1792 congressional debate, James Madison explained what he meant in Federalist No. 41. He said:

> "I, sir, have always conceived – I believe those who proposed the Constitution conceived, and it is still more fully known, and more material to observe that those who ratified the Constitution conceived – that this is not an indefinite Government, deriving its powers from the general terms prefixed to the specified powers, but a limited Government, tied down to the specified powers which explain and define the general terms....
>
> It will follow, in the first place, that if the terms be taken in the broad sense they maintain, the particular powers afterwards so carefully and distinctly enumerated would be without any meaning, and must go for nothing. It would be absurd to say, first, that Congress may do what they please, and then that they may do this or that particular thing.... ***In fact, the meaning of the general terms in question must either be sought in the subsequent enumeration which limits and***

> ***details them, or they convert the Government from one limited, as hitherto supposed, to the enumerated powers, into a Government without any limits at all.***"

Eastman, 4 Chapman L. Rev. at 80 (quoting 3 ANNALS OF CONG., House of Representatives, 2d Cong., 2d Sess. 386-87 (1792), emphasis added and internet citation omitted). Thus, in construing the Revenue Clause, the phrase "to ... provide for the ... general Welfare" further defines and limits the power "To lay and collect ..."; it does not enumerate another power.

III. THE PRESENTMENT AND BICAMERAL CLAUSES PROHIBIT THE 111TH CONGRESS FROM SPENDING ON "AUTO-PILOT" BEYOND THE END OF ITS TERM BECAUSE SUCH SPENDING WITHHOLDS LEGISLATIVE POWER FROM FUTURE CONGRESSES AND VETO POWER FROM FUTURE PRESIDENTS

The Medicaid Expansion Provisions put federal and state spending on "auto-pilot" for years to come and thereby violate the Constitution's Separation of Powers Doctrine for several reasons. First, they take the spending decision from some future Congress and transfer it to the Congress that enacted the spending legislation. Essentially, they leave future Congresses with less than all legislative powers and future Presidents with less than all their veto powers. Furthermore, future spending compels future Congresses to appropriate more money from the Treasury than they might otherwise decide to do.

As this Court has recognized, "The Constitution's division of power among the three branches is violated where one branch invades the territory of another, whether or not the encroached-upon branch approves the encroachment." *New York v. United States*, 505 U.S. at 182. In other words, the "constitutional authority of Congress cannot be expanded by the 'consent' of the governmental unit whose domain is thereby narrowed, whether that unit is the Executive Branch or the States." *Id.*

Here, however, the encroachment is more subtle and perhaps more dangerous. The 111th Congress and the President consented to spending on behalf of their successors. That is, under the MXPs, Congress and the President enlarged their own spending power by encroaching upon the legislative and veto powers of future Congresses and Presidents, respectively.

There can be no doubt that our Framers sought to diffuse power to prevent tyranny. Not only did they incorporate a Separation of Powers doctrine and the concept of federalism into the Constitution, but they provided a temporal constraint on the legislative mandate. The words of the Constitution and George Washington are clear on this point.[9]

Justice O'Connor explained the Constitution's diffusion of powers as follows:

> The Constitution does not protect the sovereignty of States for the benefit of the States or state governments as abstract political entities, or even for the benefit of the public officials governing the States. To the contrary, the Constitution divides authority between federal and state governments for the

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[9] It should not be overlooked that in addition to being our Nation's first President, George Washington also presided over the 1787 Convention that proposed the Constitution for ratification.

> protection of individuals. State sovereignty is not just an end in itself: "Rather, federalism secures to citizens the liberties that derive from the diffusion of sovereign power." *Coleman v. Thompson*, 501 U.S. 722, 759 (1991) (Blackmun, J., dissenting). "Just as the separation and independence of the coordinate branches of the Federal Government serve to prevent the accumulation of excessive power in any one branch, a healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front." *Gregory v. Ashcroft*, 501 U.S., at 458.

New York v. United States, 505 U.S. at 181-182.

Turning to the power of Congress, the Constitution provides various constraints. It is well-established that "[e]very law enacted by Congress must be based on one or more of its powers enumerated in the Constitution." *United States v. Morrison*, 529 U.S. 598, 607 (2000); *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 405 (1819). Those powers are constrained by the Constitution's procedural requirements, *see e.g.* U.S. CONST. art. I, sec. 7, cl. 2, and substantive requirements, *see e.g.* U.S. CONST. art. I, sec. 9. Another constraint is provided by the temporal limit on the legislative franchise, *i.e.*, an end in the term of office for which each member of the House and each member of the Senate was elected.

The temporal constraint comes from the words of the Constitution itself. The President and members of the Senate and members of the House of Representatives represent different geographic constituencies, have different times and modes of election, and have different requirements for holding office. U.S. CONST. art. I, secs. 2 & 3; U.S. CONST. art. II, sec. 1; and U.S. CONST. amend. XVII. The Constitution further diffuses power by limiting the terms of the President and members of the Senate and the House and by making the terms of different lengths. Senators are elected for six years. U.S. CONST. art. I, sec. 3, cls. 1&2; U.S. CONST. amend. XVII. The President is elected for four years. U.S. CONST. art. II, sec. 1, cl. 1. Members of the House of Representatives are elected for two years. U.S. CONST. art. I, sec. 2, cl. 1. Thus, the authority of each Representative, each Senator, and the President expires at the end of his or her term in office, respectively. Exercising any legislative authority beyond that point unconstitutionally transfers power from the People to choose their own representatives.

As George Washington explained the temporal constraint: “‘The power under the Constitution will always be in the People. It is entrusted for certain defined purposes, and ***for a certain limited period***, to representatives of their own chusing; and whenever it is executed contrary to their Interest, ... their Servants can, and undoubtedly will be, recalled.’” *U.S. Term Limits, Inc. v. Thornton*, 514 U.S. 779, 814 n.26 (1995) (internal citation omitted, emphasis added).

A commentator expressed the temporal constraint in real estate terms, *i.e.*, the holding of an elective office is a “temporary lease” from the nation's citizens. Alan B. Morrison, *A Non-Power Looks at the Separation of Powers*, 79 Geo. L. J. 281, 282 (1990). Expressed in real estate terms, the Constitution does not permit holdover tenancies by members of Congress or the President. By spending beyond the expiration of its term, the 111th Congress has become a "holdover" Congress.

CONCLUSION

For the foregoing reasons, the Medicaid Expansion Provisions are unconstitutional.

Respectfully submitted,

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608
aschlafly@aol.com

DAVID P. FELSHER
Counsel of Record
488 MADISON AVENUE
NEW YORK, NY 10022
(212) 308-8505
dflaw@earthlink.net

Counsel for Amici

Dated: January 17, 2012

AMICUS
CURIAE
BRIEF

Nos. 11-393 & 11-400/SEVERABILITY

IN THE
Supreme Court of the United States

FLORIDA, ET AL.,
Petitioners,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVS., ET AL.,
Respondents.

NAT'L FEDERATION OF INDEPENDENT BUSINESS, ET AL.,
Petitioners,
v.
KATHLEEN SEBELIUS, SECRETARY OF HHS, ET AL.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INDIVIDUAL PHYSICIANS and CITIZENS' COUNCIL FOR HEALTH FREEDOM AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608
aschlafly@aol.com

DAVID P. FELSHER
Counsel of Record
488 MADISON AVE.
NEW YORK, NY 10022
(212) 308-8505
dflaw@earthlink.net
Counsel for Amici

QUESTION PRESENTED

Does severance of the individual mandate of Section 1501 from the remainder of the Patient Protection and Affordable Care Act amount to a judicial line-item veto that violates the Bicameral and Presentment Clauses?

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v.

KATHLEEN SEBELIUS, SECRETARY OF HHS, ET AL.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

INTERESTS OF *AMICI CURIAE*[1]

Amici Curiae ("*Amici*") are individual physicians, a national association of physicians, and a national association of patients and physicians. *Amici* file this brief to assist the Court in defining and resolving the severability issue, one of four issues for which this Court has directed the parties and their *amici curiae* to brief. Order dated, December 8, 2011 ("Briefing Order").[2]

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[1] This brief is filed with the written consent of all parties. Those consents are filed with the Clerk of this Court. Pursuant to Sup. Ct. Rule 37.6, counsel for *Amici Curiae* authored this brief in whole, and no counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *Amici*, members of *Amici*, or *Amici*'s counsel make a monetary contribution to the preparation or submission of this brief.

Since 1943, *Amicus* The Association of American Physicians and Surgeons, Inc. ("AAPS") has been dedicated to the highest ethical standards of the Oath of Hippocrates and to preserving the sanctity of the patient-physician relationship. AAPS has filed numerous *amicus curiae* briefs in noteworthy cases like this one. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 933 (2000) (citing an AAPS *amicus* brief). Because AAPS has also commenced an action alleging that the Patient Protection and Affordable Care Act is unconstitutional, the disposition of these Petitions may affect the rights of AAPS and its members. *Association of American Physicians and Surgeons, Inc. v. Sebelius*, Case No. 1:10-cv-0499-ABJ (D.D.C.).

Amicus Citizens' Council for Health Freedom ("CCHF") is organized as a Minnesota non-profit corporation. The CCHF exists to support patient and doctor freedom, medical innovation and the right of citizens to a confidential patient-doctor relationship.

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[2] The Court has also directed briefing regarding the following issues: (1) the constitutionality of the individual mandate; (2) the applicability of the Anti-Injunction Act; and (3) the constitutionality of the Medicaid expansion provisions. Briefing Order. At this point, *Amici* may submit briefs as *amici curiae* regarding all three issues. However, *Amicus* AAPS has made a motion to intervene regarding the Anti-Injunction Act issue in connection with petition No. 11-398. If this motion is granted, the AAPS will not file a brief as *amicus curiae* regarding that issue.

Amicus Leah S. McCormack, M.D., privately practices dermatology in New York City, New York. She earned certification from the American Board of Dermatology and is a fellow of the American Academy of Dermatology. She is the immediate Past-President of the Medical Society of the State of New York.

Amicus Guenter L. Spanknebel, M.D., privately practiced gastroenterology in Massachusetts. He is a Past-President of the Massachusetts Medical Society and is currently chair of its History Committee. He has served as a Trustee of the Health Foundation of Central Massachusetts and on the faculties of the medical schools at Tufts University and the University of Massachusetts.

Amicus Janis Chester, M.D., privately practices psychiatry in Delaware, serves as chair of the Department of Psychiatry at a community hospital, is a member of the faculty at Jefferson Medical College and holds a variety of positions with organized medicine and psychiatry, locally and nationally.

Amicus Mark J. Hauser, M.D., privately practices psychiatry and forensic psychiatry in Massachusetts and Connecticut.

Amicus Graham Spruiell, M.D., privately practices forensic psychiatry and psychoanalysis in the Boston area.

Amici have followed attempts in recent years to enact health care reform legislation. As active members of the medical profession and pursuant to their ethical obligations, *Amici* have monitored the introduction, passage and partial early implementation of the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119

(2010) ("ACA"), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010) ("HCERA" or "Reconciliation Act").

For the reasons set forth below, *Amici* argue that after the Eleventh Circuit found the individual mandate of Section 1501 of ACA unconstitutional, it incorrectly severed the individual mandate of Section 1501 from the remainder of ACA.[3]

ACA undermines, in fundamental and dangerous ways, the practice of medicine, and harms patients. *Amici* argue that severance of the individual mandate of Section 1501 without invalidating all of ACA will improperly burden the practice of medicine as well as the dockets of this Court, the Courts of Appeals and the District Courts, for many years to come.

Amici respectfully suggest that the Court reconsider its approach to severability. Thus, *Amici* submit this brief to provide the Court with greater clarity on that issue.

PRELIMINARY STATEMENT

Three separate petitions were filed by the parties in this case. *Florida v. United States Department of Health and Human Services*, 648 F.3d 1235 (11th Cir. 2011). The petitioning parties include: (1) three departments of the federal government[4] and their corresponding Secretaries[5] ("Federal Petitioners") in Case No. 11-398; (2) a majority of the States[6] ("State Petitioners") in Case No. 11-400; and (3) three private parties ("Private Petitioners)[7] in Case No. 11-393. All three petitions were granted *certiorari*. At least three other petitions challenging ACA are pending (Nos. 11-117, 11-420 and 11-438).

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[3] *Amici* believe that the Eleventh Circuit correctly found that the individual mandate of Section 1501 is unconstitutional and expect to file a brief on that issue in support of Respondents in connection with Petition No. 11-398.

[4] United States Departments of the Treasury, Labor, and Health and Human Services.

The Eleventh Circuit erred by starting its analysis with a presumption of severability. 648 F.3d at 1320-21. Where, as in ACA, Congress is silent regarding severability, only a presumption of non-severability is permitted by the Constitution in light of the Bicameral and Presentment Clauses and the Separation of Powers doctrine.

When a court declares that a provision within a federal statute is unconstitutional, it must then decide whether or not that provision may be severed[8] from the statute to salvage the remainder of the statute. Often, this decision depends on whether Congress has placed a severability or non-severability clause within the statute or was silent regarding severability. In the former case, there is some guidance for the court. In the latter case, the court's initial presumption could be determinative of the outcome. Indeed, over the last two centuries, the Court's position has fluctuated. Sometimes the Court has presumed that an invalid provision is severable. Sometimes it has presumed that it is non-severable.

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[5] Timothy F. Geithner, Hilda L. Solis, and Kathleen Sebelius, respectively.

[6] Florida, South Carolina, Nebraska, Texas, Utah, Louisiana, Alabama, Michigan, Colorado, Pennsylvania, Washington, Idaho, South Dakota, Indiana, North Dakota, Mississippi, Arizona, Nevada, Georgia, Alaska, Ohio, Kansas, Wyoming, Wisconsin, Maine, and Iowa.

[7] National Federation of Independent Business, Kaj Ahlburg, and Mary Brown.

[8] *Amici* have used the following words (or a variation thereof) interchangeably within this brief: sever, excise, prune, delete, and truncate.

Amici respectfully ask the Court to focus on a single aspect of the severability doctrine that has received virtually no academic or judicial attention, *i.e.*, the striking similarity between the generally accepted power of the courts to sever an unconstitutional provision from the remainder of a federal statute and the unconstitutionality of presidential authority to exercise a line-item veto. *See Clinton v. City of New York*, 524 U.S. 411(1998).[9]

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[9] *See also* Tom Campbell, *Severability of Statutes*, 62 Hastings L. J. 1495, 1507-08, 1525 (July 2011) ("*Campbell*") (concluding that courts should apply a conclusive presumption of non-severability as required by *Chadha* and *Clinton*); Lars Noah, *The Executive Line Item Veto and the Judicial Power to Sever: What's the Difference?*, 56 Wash. & Lee L. Rev. 236, 241 (1999) ("Although commentators have criticized the Supreme Court's approach to deciding the severability of particular provisions, apparently no one has suggested that the judiciary's assertion of that power violates Article I's 'finely wrought' procedures for legislating"). Other commentators have recognized the legislative nature of severance. *See, e.g.*, David Gans, *Severability as Judicial Lawmaking*, 76 Geo. Wash. L. Rev. 639, 644-45 (1999) ("*Gans*") ("Courts cannot simply focus on legislative intent. They must also consider whether severance in any particular case amounts to impermissible judicial lawmaking."). Professor Laurence Tribe observed:

> When a severability clause is regarded as an instruction to judges that they ought to act *as if* Congress had enacted a veto-free law (or, indeed, any other law severed from a portion subsequently held to be unconstitutional), the clause seems nothing more than an invitation for courts to ***disregard the absence of any actual enactment of the severed law in accord with Article I's strictures. The con-***

By considering the Bicameral and Presentment Clauses, the Court's approach to severability will be clarified.[10] The severability doctrine has received numerous, often opposing criticisms. For example, one commentator has observed:

> [Severability doctrine] has drawn criticism on almost every conceivable basis. Commentators have condemned [it] as too malleable and as too rigid; as encouraging judicial overreaching and as encouraging judicial abdication. They have criticized the doctrine's reliance on legislative intent and its disregard of legislative intent; its excessive attention to political concerns and its inattention to political concerns.

Kevin Walsh, *Partial Unconstitutionality*, 85 N.Y.U. L. Rev. 738, 750 (2010) (internal citation omitted).

> ***stitutional safeguards of bicamerality and presentment are thereby abandoned, and a new law is created by judicial fiat.*** ... It seems especially odd for these concerns to be overlooked in *Chadha* – the very decision that held the legislative veto device void precisely because of its failure to meet the bicamerality and presentment requirements.

Laurence Tribe, *The Legislative Veto Decision: A Law by Any Other Name*, 21 Harv. J. Legis. 1, 22-23 (1984) (emphasis added, footnote omitted). In their petition-stage briefs as *Amici Curiae* in this case and in *Commonwealth of Virginia ex rel. Cuccinelli v. Sebelius*, Docket 10-1014, *Amici* urged the Court to apply the Bicameral and Presentment Clauses when considering severability.

[10] A robust and clarified severability doctrine will benefit all three branches of the federal government: the courts (when reviewing a statute), Congress (when drafting legislation) and the President (when approving or vetoing legislation).

SUMMARY OF ARGUMENT

The Court should declare that ACA is unconstitutional in its entirety because severance, in the absence of a severability clause, wreaks havoc on the Constitution's system of checks and balances and ignores the Separation of Powers doctrine. Such severance provides Congress with less than "ALL" legislative power, imposes a new "reconsideration" mechanism outside of the Presentment Clause, and is beyond the enumerated powers of Article III courts. Current severability doctrine allows Congress to wantonly avoid accountability. It lets courts prune away any unconstitutional provision, instead of requiring Congress to meet its requirement to comply with the Constitution *ex ante*. When Congress enacts omnibus legislation, such as ACA, severability analysis is impractical, if not impossible, in light of all the possible relationships among the provisions of the challenged statute.

ARGUMENT

I. THE COURT SHOULD REVISE ITS SEVERABILITY ANALYSIS BECAUSE SEVERANCE OPERATES AS A JUDICIAL LINE-ITEM VETO IN VIOLATION OF THE BICAMERAL AND PRESENTMENT CLAUSES

A. The Bicameral and Presentment Clauses Set Forth a Single Finely Wrought and Exhaustively Considered Procedure to Enact Federal Legislation

It is well established that the United States Constitution provides "a single, finely wrought and exhaustively considered, procedure" for enacting legislation. *Immigration and Naturalization Service v. Chadha*, 462 U.S. 919, 951 (1983); *Clinton v. City of New York*, 524 U.S. 417, 439-40 (1998). Strict adherence to that procedure is required and is set forth in the Bicameral Clause, U.S. CONST. art. I, sec. 1, and the Presentment Clause, U.S. CONST. art. I, sec. 7, cl. 2.

The Bicameral Clause provides "**All legislative Powers** herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives." U.S. CONST. art. I, sec. 1 (emphasis added).

The Presentment Clause provides:

> Every **Bill** which shall have passed the House of Representatives and the Senate, shall, before it becomes a Law, be presented to the President of the United States: If he approve he shall sign it, but if not he shall return it,

> with his Objections to that House in which **it** shall have originated, who shall enter the Objections at large on their Journal, and proceed to reconsider **it**. If after such reconsideration two thirds of that House shall agree to pass the **Bill**, it shall be sent, together with the Objections, to the other House, by which **it** shall likewise be reconsidered, and if approved by two thirds of that House, **it** shall become a Law. But in all such Cases the Votes of both Houses shall be determined by yeas and Nays, and the Names of the Persons voting for and against the **Bill** shall be entered on the Journal of each House respectively. If any **Bill** shall not be returned by the President within ten Days (Sunday excepted) after **it** shall have been presented to him, the Same shall be a Law, in like manner as if he had signed **it**, unless Congress by their adjournment prevent its return, in which Case **it** shall not be a Law.

U.S. CONST. art. I, sec. 7, cl. 2 (emphasis added).

The Constitution's first clause gives "ALL LEGISLATIVE POWER" to Congress. U.S. CONST. art. I, sec. 1 (emphasis added). This should have made it improper for the judiciary to exercise any legislative power, including the power to sever an unconstitutional provision from the remainder of a statute lacking a severability clause. Courts may not merely hit the delete button to excise an unconstitutional provision. By doing so, a court replaces the text of a statute that has been subjected to the Constitution's rigorous bicameral and presentment requirements with a truncated version of the text that was never passed by Congress nor presented to the President.[11] Judicial excision of legislated text, no matter how small or insignificant, is the exercise of at least a scintilla of legislative power. Congressional control of the content of legislation is absolute. This is clear from the Constitution's use of the word "ALL" within the first clause.[12] Because the definition of the word "ALL" is not in dispute, we adopt its plain meaning.[13] "All" means completely or wholly, "without admi[ss]ion of any thing el[s]e." Samuel Johnson, 1 *A Dictionary of the English Language* 133 (6th ed., 1785).[14] There is no gray area to decide or fuzzy logic to apply. The use of the word "all" provides a firm rule or "bright line" for the Court to follow. *See generally Kyllo v. United States*, 533 U.S. 27, 40 (2001).

Completely reposing legislative power in Congress is also consistent with the content of at least five other clauses in the Constitution which ensure that all legislation is produced by an independent and vibrant two-chamber national legislature. These clauses are: (1) the Rules Clause, U.S. CONST. art. I, sec. 5 ("Each House may determine the Rules of its Proceedings..."); (2) the Origination Clause, U.S. CONST. art. I, sec. 7, cl. 1 ("All Bills for raising revenue shall originate in the House of Representatives ...); (3) the Presentment Clause, U.S. CONST. art. I, sec. 7, cl. 2 (discussed above); (4) the Resolution Clause, U.S. CONST. art. I, sec. 7, cl. 3 ("Every Order, Resolution, or Vote, to which the Concurrence of the Senate and House of Representatives may be necessary ..."); and (5) the Recommendation Clause, U.S. CONST. art. II, sec. 3 (the President may only recommend laws to Congress that he or she judges are "necessary and expedient." The President has no power to introduce legislation. He or she must find at least one member of each chamber to introduce the legislation). In short, the Constitution requires the Court not to look beyond the plain meaning of the word "all".

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[11] That is, with the unconstitutional provision deleted from the original version of the text.

[12] Indeed, the word "all" is the very first word in Article I.

[13] *Connecticut National Bank v. Germain*, 503 U.S. 249 (1992) ("When the words of a statute are unambiguous ... 'judicial inquiry is complete'"). This point should apply to Constitutional interpretation as well because the word "all" at the beginning of the Bicameral Clause is completely unambiguous.

[14] http://www.archive.org/stream/dictionaryofengl01johnuoft#page/n131/mode/2up (viewed 1/4/12).

Unless a new amendment is grafted onto the Constitution, pursuant to Article V, courts lack power to reconstruct or reconstitute the text of any bill that has been enacted and become a public law ("Public Law").[15] Unless Congress includes a severability clause within the bill that it and the President ultimately enact, a court lacks power to change the law once it makes the determination that a provision within that Public Law is unconstitutional. The Public Law must be declared unconstitutional in its entirety. The binary option, "to sever" or "not to sever" exists only if Congress and the President have included a severability clause within the Public Law that has been enacted.

If this Court either: (1) affirms the finding in the decision below that the individual mandate in Section

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[15] In this brief, *Amici* use the term "Public Law" as the appropriate analytic unit. It refers to a specific bill as enacted (*i.e.*, before the deletion of the unconstitutional provision).

1501 is unconstitutional; or (2) reverses the finding that the Medicaid expansion provisions are constitutional, then this Court will have no choice but to declare that ACA is unconstitutional in its entirety because Congress did not include a severability provision within Public Law 111-148, *i.e.*, ACA.[16]

Analytically, the Court may not insert - by implication - a severability clause into ACA. Three reasons come to mind. First, the 111th Congress did, in fact, consider a severability clause in its health care legislation, but chose not to include any severability provision in the enacted version of ACA, Pub. L. 111-148.[17] Second, implying a severability clause in ACA imparts a lawmaking (*i.e.*, legislative) power to the judiciary in violation of the Bicameral Clause.[18] Third, it is beyond the Court's Article III powers to implicitly add a provision to a statute. The Court lacks subject matter jurisdiction to apply any statutory provision that was never enacted according to the Bicameral and Presentment Clauses.

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[16] *Amici* believe that numerous other provisions within ACA, including the Medicaid expansion provisions, are unconstitutional. Any of those provisions could be the predicate for declaring ACA to be unconstitutional in its entirety. Like both the individual mandate and the Medicaid expansion provisions, many of ACA's other provisions violate the Presentment Clause because they were simultaneously enacted and amended.

[17] *See* America's Affordable Health Choices Act of 2009: Report of the Committee on Education and Labor on H.R. 3200, H. Rept. 111-299, p. 17 (Section 155 provides: "If any provision of this Act, or any application of such provision to any person or circumstance, is held unconstitutional, the remainder of the provisions of this Act and the application of the provision to any other person or circumstance shall not be affected.").

[18] Judicial, Legislative and Executive powers are enumerated in Articles III, I, and II, respectively.

Application of the Bicameral and Presentment Clauses to congressional vetoes and presidential line-item vetoes were central to this Court's decisions in *Immigration and Naturalization Service v. Chadha* and *Clinton v. City of New York,* respectively. Pursuant to Article VI, the Bicameral and Presentment Clauses must be applied to any judicial attempt to delete an unconstitutional provision from a Public Law lacking a severability clause. Despite the fact that it has, at times, condoned such deletions, this Court must now declare such judicial actions to be unconstitutional.

Perhaps the most interesting aspect of this case, if not the most ironic, is that the judicial remedy – the striking of an unconstitutional provision from the remainder of the statute in question in both *Marbury v. Madison*, 5 U.S. (1 Cr.) 137 (1803), and *Chadha* – is itself inconsistent with the Constitution, *i.e.*, the Bicameral and Presentment Clauses.[19]

The Constitution separated legislative, executive and judicial powers in order to prevent tyranny. Severability in the absence of a severability clause, by ignoring the Bicameral and Presentment Clauses, transfers some power from Congress[20] and the President (regarding the power of the President to approve or veto legislation passed by both Houses)[21] to the judiciary.

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[19] The *Marbury* Court concluded that "the particular phraseology of the constitution of the United States confirms and strengthens the principle ... that ***courts, as well as other departments, are bound by that instrument*.**" 5 U.S. at 180 (emphasis added).

[20] The power to control the content of legislation as well as the power to "reconsider" any legislation vetoed by the President.

B. Judicial Line-Item Vetoes Are as Unconstitutional as Presidential Line-Item Vetoes and Congressional Vetoes

There is no reason to believe that the Constitution allows the judiciary to retain a judicial line-item veto, because presidential line-item vetoes are unconstitutional and congressional vetoes are unconstitutional. *See Clinton*, 524 U.S. at 447-49; *see also Chadha*, 462 U.S. at 959. Although this Court has previously severed defective provisions from federal statutes, *see, e.g.*, *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 697 (1987) ("*Alaska Airlines*"), that remedy should be unavailable to courts without a congressionally enacted severability clause considering *Clinton and Chadha*. The Bicameral and Presentment Clauses require the House and Senate to pass precisely the same text – not a single word or punctuation may vary between the bills passed by each chamber. *See Clinton,* 524 U.S. at 448. The judiciary, like the President, has no power to rewrite a statute.[22] Furthermore, the idea that the judiciary be joined with the executive in a "council of revision" was considered and expressly rejected by the Drafters of the Constitution. Brief of Senators Robert C. Byrd, Daniel Patrick Moynihan, and Carl Levin as *Amici Curiae* in Support of Appellees 9-10 in *Clinton v. City*

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[21] Furthermore, when a court severs the text of a Public Law, the President never has the opportunity to approve the new text of the Public Law nor to direct Congress to "reconsider" the new text if he or she objects to the new text.

[22] Nor may Congress transfer its power to the judiciary.

of New York (Docket No. 97-1374) ("*Byrd-Moynihan-Levin Brief*"). The Constitution's Bicameral Clause gives "ALL" legislative power to Congress. Because the power to sever is the power to determine the content of legislation, it may not be exercised by the courts in the absence of congressional inclusion of a severability clause.

Furthermore, any judicial action to revise a statute is legislative in purpose and effect because "it alter[s] the legal rights, duties and relations of persons ... outside the Legislative Branch." *Chadha*, 462 U.S. at 952.

It is clear from the Presentment Clause and as held in *Clinton* that partial vetoes are not permitted. This *in toto* requirement was understood by Presidents Washington[23] and Taft[24] as well as the late Senator Moynihan, a noted constitutional scholar.[25] The *in toto* requirement should apply to the deconstruction of a statute by the courts in the same way that it applies to the deconstruction of a statute by the President.

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[23] *Accord* Letter from George Washington to Edmund Pendleton (Sept. 23, 1793), *reprinted in* 33 *The Writings of George Washington* 94, 96 (John C. Fitzpatrick, ed. 1940) ("From the nature of the Constitution, I must approve all the parts of a Bill, or reject it in toto"). President Washington also served as President of the 1787 Convention that promulgated the Constitution.

[24] William H. Taft, *The Presidency: Its Duties, Its Powers, Its Opportunities and Its Limitations* 11 (1916) (The President "has no power to veto part of the bill and allow the rest to become a law"). William H. Taft was the only person to serve both as President and Chief Justice of this Court.

[25] *See* 141 Cong. Rec. S4443-4449 (104th Cong. 1st Sess. 1995). The repeated use of the terms "the Bill", "it", "its" and "reconsider" in the Presentment Clause are consistent with the proposition that a bill that was passed by both Houses of Congress and presented to the President is ***indivisible***.

C. If This Court Applies the Bicameral and Presentment Clauses to Severability, It Can Avoid the Inconsistency that Has Plagued Its Prior Cases

1. The Current Severability Test is Set Forth in *Alaska Airlines v. Brock*

The traditional test for severability is well-established:

> The standard for determining the severability of an unconstitutional provision is well established: Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (internal quotation marks omitted). While the Act itself contains no statement of whether its provisions are severable, "[i]n the absence of a severability clause, ... Congress' silence is just that – silence – and does not raise a presumption against severability." *Id.* at 686....

New York v. United States, 505 U.S. 144, 186 (1992). As a matter of logic and judicial consistency, congressional silence should not raise a presumption favoring severability. Therefore, *Amici* question the presumption of severability used by the Eleventh Circuit. The Eleventh Circuit stated:

> In analyzing [the severability of the individual mandate of Section 1501 from ACA,] we start with the settled premise that severability is fundamentally rooted in a respect for separation of powers and notions of judicial restraint. *See Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 329-30 [(2006)]. Courts must "strive to salvage" acts of Congress by severing any constitutionally infirm provisions "while leaving the remainder intact." *Id.* at 329 .... "[T]he presumption is in favor of severability." *Regan v. Time, Inc.*, 468 U.S. 641, 653 [(1984)].

648 F.3d at 1320-21.[26]

2. Classification and Summary of Severability Cases

Amici suggest that, for analytic purposes, the Court utilize the following categories of cases in its review of prior cases: Category 1 - Express Severability Clauses; Category 2 – Express Non-Severability Clauses; Category 3 – Presuming Severability if Congress is Silent; and Category 4 – Presuming Non-Severability if Congress is Silent.

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[26] The Eleventh Circuit stated: "In the overwhelming majority of cases, the Supreme Court has opted to sever the constitutionally defective provision from the remainder of the statute." *Florida v. United States HHS*, 648 F.3d 1235, 1321 (11th Cir. 2011) (citations omitted). The Eleventh Circuit supports its analysis with references to the House and Senate drafting manuals. 648 F.3d at 1322 ("First, both the Senate and House legislative drafting manuals state that, in light of Supreme Court precedent in favor of severability, severability clauses are unnecessary unless they specifically state that all or some portions of a statute should *not* be severed.") (internal citations omitted, emphasis in original).

Often during the Twentieth Century, the Court has had to deal with many statutes that contained a severability clause. *See, e.g., Chadha,* 462 U.S. at 931-932 ("[I]nvalid portions of a statute are to be severed, unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not. ... Here, however, ... Congress itself has provided the answer to the question of severability ....") (internal quotations and citations omitted).

In *Electric Bond & Share Co. v. S.E.C.*, this Court declared:

> This provision reverses the presumption of inseparability – that the Legislature intended the act to be effective as an entirety or not at all .... Congress has thus said that the statute is not an integrated whole, which as such must be sustained or held invalid .... Invalid parts are to be excised and the remainder enforced. When we are seeking to ascertain the Congressional purpose, we must give heed to this explicit declaration.

303 U.S. 419, 434 (1938). *See also Williams v. Standard Oil Co.*, 278 U.S. 235, 241 (1928) ("In the absence of such a legislative declaration, the presumption is that the Legislature intends an act to be effective as an entirety.").

Although *Amici* have not found a Supreme Court case with an express non-severability clause, the court below did address the possibility of such a clause. In fact, the Eleventh Circuit referred to the House and Senate Drafting Manuals which suggested that Congress could include a Non-Severability Clause if Congress wishes the Court to overcome the presumption of severability. 648 F.3d at 1322-23. *Amici* strongly challenge the premise that there is a presumption of severability to be used by the courts.

From the beginning of judicial review of statutes by the federal judiciary until today, a number of courts have, where Congress is silent, merely presumed that an unconstitutional provision is severable from the remainder of the statute. *See, e.g.*, *Marbury v. Madison*, 5 U.S. at 173-80 (According to *Gans*, 76 Geo. Wash. L. Rev. at 639 n.1, "[t]he [severability] doctrine is implicit in *Marbury v. Madison*, ... which invalidated one particular section of the Judiciary Act of 1789, ch. 20, 1 Stat. 73, leaving the remainder in place."); *Bank of Hamilton v. Lessee of Dudley*, 27 U.S. 492, 526 (1829) ("If any part of the act be unconstitutional, the provisions of that part may be disregarded while full effect will be given to such as are not repugnant to the constitution of the United States ...."); *Champlin Refining Co. v. Corp. Commission of Oklahoma*, 286 U.S. 210, 234 (1932) ("Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law."); *Regan v. Time*, 468 U.S. at 653; and *Alaska Airlines*, 480 U.S. at 684.

This view has been adopted by the counsels for both the House and Senate, who apparently never considered the Bicameral and Presentment Clauses. House Counsel observed that:

> The Supreme Court has made it quite clear that invalid portions of statutes are to be severed unless it is evident that the Legislature would not have enacted those provisions which are within its

> powers, independently of that which is not. ... Consequently, a severability clause is unnecessary unless it provides in detail which related provisions are to fall, and which are not to fall, if a specified key provision is held invalid.

Office of Legislative Counsel, United States House of Representatives, *House Legislative Drafting Manual*, Sec. 328 (Nov. 1995) (internal citations and quotation marks omitted"). *See also* Office of Legislative Counsel, United States Senate, *Legislative Drafting Manual*, Sec. 131 (Feb. 1997) ("The Supreme Court has made it clear that an invalid portion of a statute is to be severed unless it is evident that the Legislature would not have enacted those provisions which are within its powers, independently of that which is not. ... Consequently, a severability clause is unnecessary.") (internal citations and quotation marks omitted).

Other cases have presumed non-severability when Congress is silent. In *Carter v. Carter Coal*, for example, this Court explained:

> In the absence of such a provision, the presumption is that the Legislature intends an act to be effective as an entirety – that is to say, the rule is against the mutilation of a statute; and if any provision be unconstitutional, the presumption is that the remaining provisions fall with it.

298 U.S. 238, 312 (1936).

3. The Court Should Adopt a "Bright Line" Test Regarding Severability in the Absence of a Congressionally Enacted Severability Clause

The Court should now put aside its past severability practice when it finds a statute that contains an unconstitutional provision and that statute is silent with respect to severability. Only by: (1) employing a conclusive presumption of non-severability; and (2) voiding the entire statute containing the unconstitutional provision will the requirements of the Constitution's Bicameral and Presentment Clauses be satisfied. The Constitution definitively stated that "All Legislative Power" is vested in Congress. Nothing could be clearer.

II. A JUDICIAL LINE-ITEM VETO ENDANGERS THE DISPERSION OF POWERS WHICH UNDERLIES AND IS INCORPORATED INTO THE CONSTITUTION

Amici challenge the notion that severance is an act of judicial restraint. Rather, *Amici* ask the Court to consider that severance of the individual mandate of Section 1501 from ACA would be an act of judicial activism at its zenith, not its nadir, because such severance amounts to a judicial line-item veto in that it allows the judiciary to determine the content of a law after it has been enacted. Therefore, severance is a doctrine of judicial activism that allows, and possibly even encourages, constitutional sloppiness by Congress and the President.

The Constitution diffuses power both horizontally and vertically. First, power is divided between the federal government and the states. Then, federal power is further divided into three separate branches: the Legislative, Executive, and Judicial Branches. The legislative power is further sub-divided into two separate chambers: Senate and House of Representatives. The separation of powers between and among the branches lies at "the heart of our Constitution." *Buckley v. Valeo*, 424 U.S. 1, 119 (1976).

To foster this separation, the Constitution provides a single process by which the separate branches combine their diffused powers to create federal law. As this Court held in *Chadha* and *Clinton*, that process is set out in detail in the Bicameral and Presentment Clauses. When a court exercises a judicial line-item veto and severs a defective provision, it impermissibly tampers with that process and realigns the Constitution's diffusion of powers.

Our representative republic demands that Congress be accountable to the electorate. Severability interferes with that accountability and thereby reduces our liberty. Congress must be prevented from escaping and deflecting its constitutionally assigned duty to make our nation's hard policy choices through legislation. When a court reconstructs a statute, the post-severance statute cannot be said to have been enacted by democratically elected officials.

The bicameral system to enact federal legislation that was crafted by the Framers may be viewed as requiring four concurrences. First, the House of Representatives must agree within itself to the text of a bill.[27] Second, the Senate must also agree within itself to the text of a bill.[28] Third, the text of the House-passed bill must exactly match the text of the Senate-passed bill.[29] Fourth, once the House and Senate agree to the same text of a bill, that bill is presented to the President for his agreement or veto.

But when a court excises an invalid provision from a statute lacking a severability clause, the final product (*i.e.*, the new statute) is not obtained through a concurrence of the "people" and the "States", as was contemplated by the Framers.

In creating a new law that was not subject to bicameral passage, severability eviscerates the genius of the Constitution's lawmaking system. A brief by three prominent U.S. Senators in the line-item veto case explained this as follows:

> Clashes of interest are an inevitable part of representative democracy in a continental nation whose "so many separate descriptions of citizens" embrace, as Madison observed [...] , a "great variety of interests, parties and sects." The Framers anticipated and respected clashes of interest, while providing for accommodation through a process of discussion and compromise.
>
> Applying a new "science of politics," The Federalist No. 9, p. 51 (Hamilton), the Framers

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[27] By a majority vote.

[28] By a majority vote.

[29] In explaining the Great Compromise, Madison said: "No law or resolution can now be passed without the concurrence, first, of a majority of the people, and then of a majority of the States." The Federalist, No. 62 (Madison) (Clinton Rossiter, ed., at 378). In other words, the House of Representatives represents the people and the Senate represents the States.

> not only accepted human nature, *id.* No. 51, p. 349 (Madison) but enlisted it to help bring about an enduring republic. There would be conflicts. "Ambition must be made to counteract ambition," Madison wrote. Thus, **the Constitution is organized around devices that offset "by opposite and rival interests, the defect of better motives."** *Id.* Throughout our history Members have supported measures to achieve progress in other regions "for the common benefit." But the Framers also expected members would often be "partisans of their respective States." The Federalist, No. 46, p. 318 (Madison).

Byrd-Moynihan-Levin Brief at 15-16 (footnote deleted, emphasis added).

During the Constitutional Convention, at a point when the convention was sharply divided and its future in jeopardy, Benjamin Franklin spoke eloquently of the need to compromise. Franklin made his point by drawing an analogy between carpentry and legislating. He said:

> When a broad table is to be made, and the edges (of planks do not fit) the artist takes a little from both, and makes a good joint. In like manner here both sides must part with some of their demands, in order that they may join in some accommodating proposition.

Id. at 16 n.10 (quoting 1 Farrand 488)).

The Framers had the common sense to realize that the ability to reach a compromise could turn on the vote of a single member of either House. To prevent a deadlock in the Senate, the Framers provided that the Vice President would cast a vote when the members cast an equal number of votes in support of and in opposition to a bill. U.S. CONST. art. I, sec. 3, cl. 4. It is highly unlikely, that when a bare majority of Senators vote to support a complex and lengthy bill, that the same provisions were important to all of them. If the bill lacked the provision that was important to a particular Senator or Representative, he or she may not have voted for the bill. The vote would have been "nay" instead of "yea" and the bill would have failed. When a court severs an invalid provision, it creates a truncated version of the bill that might never have passed the Congress. *See Byrd-Moynihan-Levin Brief* at 17.

When a court excises an invalid provision from a statute, it eliminates the Presentment Clause's legislative filters that were designed to retard or prevent the enactment of unwise or unconstitutional legislation. Severance transforms the pre-severance text of a statute from one that complies with the Bicameral and Presentment Clauses into text which was never exposed to those clauses. Under the Presentment Clause each Chamber of Congress, *i.e.*, the Senate and the House of Representatives, must pass exactly the same bill before it can become a law. In other words, each chamber has an absolute veto with respect to prospective legislation. In contrast, the Presentment Clause provides the President with only a qualified veto - one that may be overridden only by the agreement of two thirds of the members of both Houses. Thus, the President's qualified veto power may be viewed as a "semi-permeable membrane." In contrast, each chamber's absolute veto power over legislation may be analogized to an impermeable membrane that can never be breached.

When an invalid provision is judicially severed from a statute lacking a severability clause, it interferes with the legislative role of Congress. It may be viewed either: (1) as a cession or abdication of congressional power; or (2) as an aggrandizement of power by the courts. In any case, the result is the same: it is not permitted. The Court should not forget that the dangers of a legislature ceding its power to others are real. During a five month period,[30] Senator Byrd lectured his colleagues that ceding the Senate's power to control the content of a statute is analogous to actions taken by the Roman Senate which ultimately led to the decline and fall of the Roman Empire. 139 Cong. Rec. S 5475-79, 5724-27, 5975-78, 6395-98, 6982-85, 7157-60, 7539-42, 8157-60, 8582-85, 9097-9100, 9786-89, 10971-75, 11953-56, 13561-65 (103d Cong. 1st Sess. 1993). Permitting courts to exercise a judicial line-item veto (*i.e.*, the power to sever an unconstitutional provision from a statute lacking a severability clause) is precisely such a cession of congressional power.

Furthermore, when an invalid provision is excised from a statute, it interferes with the President's role in legislating. First, the President never approves the truncated version (*i.e.*, post-severance) of the statute. Second, the President is denied his or her veto power over the truncated version of the text (*i.e.*, the power to direct reconsideration of the post-severance statute including objections specified by the President).

Besides violating the explicit terms of the Presentment Clause, severability, without a congressionally enacted severability clause, damages the legislative process in other ways. Michael Shumsky, *Severability, Inseverability, and the Rule of Law*, 41 Harv. J. Legis. 227, 277-278 (2004). As the court knows:

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[30] In connection with the debate over the presidential line-item veto.

> Most legislation ... is the culmination of myriad deals made among competing interests. The complexities and calculations of the logrolling process, and the limits it imposes on the strength of statutes, thus mandate heightened attention to the specifics of the legislative deal.

Id. at 267. When the court severs an invalid provision from a statute lacking a severability clause, it ignores this calculus. Judge Easterbrook explained:

> "[Because] legislation grows out of compromises among special interests, ... a court cannot add enforcement to get more of what Congress wanted. ***What Congress wanted was the compromise, not the objectives of the contending interests***. The statute has no purpose. It is designed to do what it does in fact. ***The stopping points are as important as the other provisions.***

Id. (quoting Frank Easterbrook, *Foreword: The Court and the Economic System*, 98 Harv. L. Rev. 4, 46 (1984), first emphasis added). When Congress includes a severability clause, as it often does, these considerations do not come into play. These considerations should come into play here because ACA lacks such a clause.

Another flaw in the existing approach to severability is that it instills the wrong set of incentives for Congress. The practice of judicial severance of an invalid provision from a statute:

> overprotects the legislature's freedom to innovate at the cost of reducing its incentives to attend to constitutional norms *ex ante* (*i.e.*, in drafting legislation). If courts are willing to save a statute by severing ... even when that entails substantial rewriting, the legislature has much less of a reason or incentive to respect constitutional norms at the outset. ***Courts, not legislators, are tailoring statutes to conform to constitutional norms. Over time the legislature may come to depend on the courts to fix statutes rather than doing the hard work necessary to enact a properly tailored statute in the first instance.*** Politically, legislators may prefer this arrangement, for it frees them to pass the statute they want, knowing the courts will save as much of their handiwork as they can. But this arrangement breeds an unhealthy dependency on courts and results in a loss of accountability. When courts substantially rewrite statutes to save them, the resulting work is as much that of the judiciary as of the legislature. That makes it hard to hold the legislature accountable for the statute that the judiciary puts in place.

Gans, 76 Geo. Wash. L. Rev. at 644 (emphasis added).

Ironically, enforcing a conclusive presumption of non-severability will encourage Congress to write constitutional laws and include severability clauses where appropriate. Indeed,

> [t]he surest way to insure that Congress addresses severability is to discipline it into doing so: If the courts, for lack of a severability clause, wholly invalidate a statute ... and announce that they

> will continue to do so in the future, Congress will learn its lesson: It will tell the courts what to do. This, after all, is the moral of *Warren* and its progeny. Dissatisfied with the courts' invalidation of partially unconstitutional statutes ..., legislatures began including severability clauses in constitutionally questionable legislation. Now they will *always* do so.

Shumsky, *supra* at 276 (emphasis in original) (*Warren* refers to the Massachusetts case of *Warren v. Mayor and Aldermen of Charlestown*, 68 Mass. 84 (1854)).

Like the President, in the exercise of his or her veto power, a court should examine the legislation *in toto*. And, if the court determines that a provision within the "bill" is not constitutional, then it must declare that the entire "bill" is not constitutional. By striking down a "bill" in its entirety, instead of reconstructing or reformulating the "bill", the court protects the separation of powers contemplated by the Framers and incorporated into the Constitution. Such an action preserves the Court's proper role. The Court is an adjudicatory body, not a legislative body. *See* Note, *Cleaning Up For Congress: Why Courts Should Reject the Presumption of Severability in the Face of Intentionally Unconstitutional Legislation*, 76 Geo. Wash. L. Rev. 698, 712 (2008).

The Court is not empowered to rewrite a statute. It must reject the entire piece of legislation (*i.e.*, the enacted Public Law). Its text may not be changed without reconsideration and renegotiation by Congress. Only with bicameral passage and presentment to the President may the legislation be rewritten.

III. ACA IS UNCONSTITUTIONAL IN ITS ENTIRETY BECAUSE THE INDIVIDUAL MANDATE IS UNCONSTITUTIONAL

The District Court concluded that the individual mandate of Section 1501 is not severable from the remainder of ACA, and declared ACA invalid in its entirety. *Florida v. United States HHS*, 780 F. Supp. 2d 1256, 1299-1305, 1307 (N.D. Fla. 2011). In contrast, the Eleventh Circuit concluded that the individual mandate of Section 1501 is severable. 648 F.3d at 1320-28. This Court should review the severability issue *de novo* and reconsider its test for severability.

A. Application of the *Alaska Airlines v. Brock* Standard Is Impractical, If Not Impossible, Because of ACA's Length and Complexity

Application of the existing severability standard is impractical, if not impossible, in this case. The Court would have to consider Section 1501's relationships with each of ACA's other provisions as well as various combinations of ACA's other provisions.[31] To illustrate this point, consider that there are 511 possible relationships among the nine Justices of this Court.[32] Assuming *arguendo* ACA contains 450 separate provisions (as recognized by the District Court, 780 F.Supp.2d at 1304), a court might have to consider as many as ($2^{449} - 1$) separate relationships among ACA's remaining provisions to conduct a thorough severability analysis.[33] Courts lack the time, manpower and computer resources to conduct such an analysis.

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[31] *Campbell*, 62 Hastings L. J. at 1507-08 and 1525 (concluding that courts should apply a conclusive presumption of inseverability as required by *Chadha* and *Clinton*).

[32] Calculated by adding together the number of 1, 2, 3, 4, 5, 6, 7, 8, and 9 Justice combinations. That sum equals $(2^9 - 1)$.

In addition to violating the Constitution's letter and spirit, the practice of severing a defective provision from a statute lacking a severability clause is bad policy because: (1) it facilitates legislative sloppiness – a bill's author knows the constitutionality of its provisions will be addressed piecemeal; (2) it allows judicial activism - a court can substitute its own judgment for the legislative bargain that was struck in Congress and agreed to by the President;[34] and (3) it encourages omnibus legislation – which members of Congress may not have sufficient time to read and understand prior to casting their votes.[35]

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[33] This number can be expressed with approximately 135 digits – 35 digits longer than the number googol, which is one followed by one hundred zeros.

[34] Congress, like other legislatures, is an institution that is conducive to vote trading and log-rolling activities. To enact a law, a majority coalition must be formed. Consequently, members of Congress often cooperate to further an individual or collective agenda. Passage of a bill might require the vote of a single member of the House or Senate. If ACA had contained a severability clause, the legislative bargain made by members of Congress probably would not have been reached. Indeed, a severability clause was included in an early draft of ACA, but was excluded from ACA as enacted.

[35] The Presentment Clause directs "reconsideration" of vetoed bills - implicitly requiring members of Congress to actually "consider" a bill. The lack of "consideration" is apparent since it took

B. Separately, the Court Should Hold that ACA Is Entirely Unconstitutional If It Holds That the Medicaid Expansion Provisions Are Unconstitutional

Assuming *arguendo* that the Court finds the Medicaid expansion provisions are unconstitutional, ACA must be declared unconstitutional in its entirety because, as argued above, courts are prohibited from exercising a judicial line-item veto by the Bicameral and Presentment Clauses and the Separation of Powers doctrine.

Regardless of the deference accorded to Congress, a court may not sever a defective provision from a statute in the absence of a severability clause because such severance is a judicial line-item veto. As explained above, this practice substantially alters the dispersion of powers specified by the Constitution. It is time to return "all legislative power" to Congress as required by the Constitution's first clause. U.S. CONST. art. I, sec. 1, cl. 1.

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almost two months after ACA and HCERA were enacted for the Office of Legislative Counsel of the House of Representatives to produce its ACA Compilation Report and for Ernst & Young, one of the Big 4 accounting/consulting firms, to issue its summary of the statutes. *See* Office of the Legislative Counsel, United States House of Representatives, 111th Cong.. 2d Sess., *Compilation of Patient Protection and Affordable Care Act [As Amended Through May 1, 2010]* at 833 *et seq. available at* http://docs.house.gov/energycommerce/ppacacon.pdf (viewed 10/23/11). *See also* Ernst & Young, LLP, *Summary of the Patient Protection and Affordable Care Act, incorporating The Health Care and Education Reconciliation Act (May 2010)* (This summary is 159 pages long).

CONCLUSION

For the foregoing reasons, ACA should be declared unconstitutional in its entirety.

Respectfully submitted,

ANDREW L. SCHLAFLY
939 OLD CHESTER ROAD
FAR HILLS, NJ 07931
(908) 719-8608
aschlafly@aol.com

DAVID P. FELSHER
Counsel of Record
488 MADISON AVENUE
NEW YORK, NY 10022
(212) 308-8505
dflaw@earthlink.net

Counsel for Amici

Dated: January 6, 2012

AMICUS CURIAE BRIEF

No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, ET AL.,
Petitioners,

v.

UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Eleventh Circuit

BRIEF OF JAMES F. BLUMSTEIN, AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS
(Medicaid Issue)

JAMES F. BLUMSTEIN
Counsel of Record
VANDERBILT UNIVERSITY
SCHOOL OF LAW
131 21ST AVENUE S.
NASHVILLE, TN 37203-1181
(615) 322-3710
James.Blumstein@Vanderbilt.edu

Counsel for Amicus Curiae

January 17, 2012

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTION PRESENTED

Does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress' spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?

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INTEREST OF *AMICUS CURIAE*

This brief *amicus curiae* is filed by and on behalf of James F. Blumstein. Mr. Blumstein is University Professor of Constitutional Law and Health Law and Policy at Vanderbilt Law School and Vanderbilt University Medical School, Director of the Vanderbilt Health Policy Center, Adjunct Professor of Health Law at Dartmouth Medical School, and, during 2010-11, Scholar-in-Residence at the Robert Wood Johnson Health Policy Center at Meharry Medical College. Professor Blumstein has been an active teacher/scholar in health law and policy for over thirty-five years and believes that his perspective will assist this Court in its deliberations. A brief biography of Professor Blumstein is in the Appendix.

In this brief, Professor Blumstein speaks for himself, not his institutional affiliations.[1]

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[1] No counsel for any party authored this brief in whole or in part, nor did any party, person or entity other than *amicus* make a monetary contribution to the preparation/submission of this brief. Reimbursement for printing expenses will be sought from funds made available by Vanderbilt Law School to support faculty work related to faculty professional/research interests. Such financial support does not signify a position by the University on the merits of the positions advanced in this Brief. The parties have blanketly consented to the filing of *amicus* briefs.

SUMMARY OF ARGUMENT

Medicaid, enacted under the federal spending power, "is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." Pennhurst State School & Hosp. v. Halderman, 451 U.S. 1, 17 (1981).

Contract law distinguishes between contract formation and contract modification. At contract formation, parties have maximum freedom to determine whether or not to enter into an agreement and to settle on the terms of that agreement. At contract modification, concerns about excessive leveraging significantly constrain the behavior of the contracting parties. The law limits opportunistic/predatory behavior.

Under the anti-commandeering principle, the federal government cannot constitutionally compel states to enter into such contracts, nor can it impose conditions involuntarily on states. Printz v. United States, 521 U.S. 898, 925 (1997); New York v. United States, 505 U.S. 144, 166, 174-78 (1992).

The anti-commandeering principle has been recognized not only in the regulatory but also in the spending context. States are and constitutionally must be free to determine whether or not to enter into a contract with the federal government to receive federal funds. Thus, this Court has acknowledged that "[t]he legitimacy of Congress' power to legislate under the spending power... rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" Pennhurst, 451 U.S. at 17.

State autonomy is protected under the anti-commandeering principle in two related ways. Federal conditions on spending programs must not be coercive – a functional dimension of anti-commandeering; and states must receive "clear notice" in advance of entering into a federal spending program of the obligations/conditions it incurs.

Acting at contract modification, PPACA is coercive because it puts states to a set of choices that the federal government may not impose on states.

PPACA also violates the Pennhurst clear-notice obligation because that obligation accrues in this case at contract formation, not contract modification.

Pennhurst requires that, when states choose to participate in a federal program, they do so fully informed of the fiscal consequences. And there cannot be "knowing acceptance" by a state of federal conditions on a program if it is "unaware of the conditions" being imposed or is unable to "ascertain what is expected of it." Therefore, for conditions on federal spending to be binding on a state, the federal government must state those conditions "unambiguously" so as to "enable the States to exercise their choice knowingly, cognizant of the consequences of their participation." Id.("clear-notice rule"). See South Dakota v. Dole, 483 U.S. 203, 207 (1987)(reaffirming that restrictions on federal spending power include Pennhurst's clear-notice rule). Thus, the federal government had an obligation, when states voluntarily signed-up to participate in Medicaid (the contract-formation stage), to put states on notice unambiguously of the nature, scope, and magnitude of their potential financial obligations under the program. Pennhurst, 451 U.S. at 17. Providing notice of substantial and unforeseeable changes to Medicaid, as effected by PPACA at the contract-modification stage, does not satisfy the federal government's clear-notice obligation under Pennhurst.

The essence of Pennhurst's clear notice rule is that notice is given in advance – allowing states and their decisionmakers to make informed choices about accepting conditions on federal funding that states cannot otherwise be compelled to accept. This Court views the issue "from the perspective of a state official who is engaged in the process of deciding whether the State should accept [federal] funds and the obligations that go with those funds." Does the federal program provide "clear notice" regarding the scope of a state's obligations, and would the state and its officials "clearly understand" the conditions that attach to a state's decision to enter into a cooperative federalism contract? Arlington Central School Dist. Bd. of Educ. v. Murphy, 548 U.S. 291, 298 (2006).

The clear-notice rule protects a state's constitutionally-derived authority to make "an informed choice," Pennhurst, 451 U.S. at 25, when it chooses to enter into a federal-state contract and accepts federal funding. The federal government may not "surpris[e] participating States with postacceptance or 'retroactive' conditions." Id. The clear-notice rule protects the rights of states not to enter into or "implement" Medicaid – *i.e.*, not to form a federal-state contract. Printz, 521 U.S. at 925; New York, 505 U.S. at 176.

The clear-notice rule is not satisfied when states are lured into a federal—state relationship on one set of expectations and then informed that, through contract modification, the fiscal implications of remaining in the program have been substantially and unforeseeably ratcheted up. Providing states with notice of their right of "exit" from an ongoing, already-formed relationship – mandating affirmative enactment of state legislation to exit the federal-state program – is not a substitute for enabling states to "exercise their choice" of entering into a federal-state contract "cognizant of the consequences of their participation," Pennhurst, 451 U.S. at 17, and thereby "knowingly undertak[ing]" an obligation based on an "informed choice." Id. at 25.

Traditional Medicaid does not satisfy the Pennhurst clear-notice requirement, nor does PPACA.

Medicaid. When enacted in 1965, Medicaid was linked to eligibility for public assistance. It was widely understood as poverty medicine. When they agreed to participate in Medicaid, states could not reasonably foresee that a condition of participation (as established under PPACA) would be the mandated inclusion of adults with incomes up to 133% of poverty in state Medicaid programs – a substantial modification of the terms and conditions of states' participation.

PPACA. PPACA provides notice that, effective January 1, 2014, states must include in their Medicaid programs all persons with incomes below 133% of poverty or act affirmatively to exit Medicaid entirely. That notice is insufficient under Pennhurst. It occurs too late – after states have already made the decision to implement a Medicaid program based on the terms and conditions at the contract-formation stage. It imposes on states a duty to act affirmatively to resist the new terms and conditions, undoing state legislation enacted to comply with Medicaid. Forcing that type of affirmative state conduct because of the federal imposition of substantial mid-stream changes in conditions of participation in Medicaid is in tension with Printz's ban on commandeering. It is not the notice required by Pennhurst.

PPACA's notice does not come at the contract-formation stage – when states made their constitutionally protected choice to enter into Medicaid – but at the contract-modification stage of an ongoing, already-formed federal-state contractual relationship. By analogy to procedural due process, this notice does not come "at a meaningful time and in a meaningful manner." Fuentes v. Shevin, 407 U.S. 67, 80 (1972)(internal cite omitted).

PPACA allows states with already-formed and ongoing federal-state Medicaid contractual relationships to leave Medicaid entirely through affirmative political action of opting out; but providing notice that allows a state affirmatively to abandon an already-existing and ongoing contractual relationship does not satisfy the Pennhurst obligation to provide notice before a state chooses to participate in the Medicaid program in the first place so that a state can exercise its constitutionally-protected choice to determine whether to participate "cognizant of the consequences of their participation." 451 U.S. at 17.

In sum, what Pennhurst requires is more than what PPACA provides. Notice of substantial, unforeseeable, and expensive mandatory modifications to Medicaid, accompanied by an opportunity to exit through an affirmative state legislative act – to undo a previously-entered and ongoing contractual relationship – is not a substitute for the notice required by Pennhurst when program modifications (i) are substantial and unforeseeable at the sign-up stage (contract formation), (ii) have a significant fiscal impact on state-administered programs, and (iii) comprise a substantial component of a state's overall budget (as Medicaid does).

ARGUMENT

I. Federal Spending Programs: The Contract Paradigm

Spending Clause legislation such as Medicaid (a cooperative federalism program) is "much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions," Pennhurst, 451 U.S. at 17, which the federal government cannot impose through compulsion. New York, 505 U.S. at 188 ("The Federal Government may not compel the States to enact or administer a federal regulatory program"). The nature, scope, and implementation/enforcement of obligations attached to federal spending are governed by principles of contract law.[2]

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[2] Contract law is an "analogy." Barnes v. Gorman, 536 U.S. 181, 186 (2002). Not all contract-law rules apply to Spending Clause legislation. Id. at 188 n.2.

A. Contract Formation Versus Contract Modification: The Leveraging Problem

The law of contract draws a critical distinction between contract formation and contract modification. Parties are subject to more restraints when they modify than when they form a contract. See Timothy J. Muris, Opportunistic Behavior and the Law of Contracts, 65 MINN. L. REV. 521 (1981); WILLISTON ON CONTRACTS (4th ed. 2008)(Richard A. Lord ed.), vol. 3 at 695-719. For example, there is a duty of fair and equitable treatment at contract modification that has no counterpart at contract formation. And the notion of "fair and equitable" goes beyond absence of coercion. Rest.2d Contracts, §89, comment b.

At contract modification, a major concern is excessive/predatory leveraging. Parties build up reliance and dependence in an ongoing relationship. That can allow for opportunistic behavior that uses predatory leverage to yield results that are beyond what was originally contemplated.[3] Consider the following illustration of the problem:

> **A fishing vessel goes out to sea. Once the ship is in fishing waters, the crew demands a substantial wage increase as a condition of performing its work. That is predatory leveraging and unenforceable at contract modification. In contrast, it is entirely**

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[3] See Robert W. Gordon, Macaulay, MacNeil, and the Discovery of Solidarity and Power in Contract Law, 1985 WIS. L. REV. 565, 570 (1985)(noting that, over time, a power imbalance in the initial contract formation can "deepen[] into persistent domination on one side and dependence on the other").

permissible for the crew to demand higher wages before the ship sets sail – *i.e.*, during the contract-formation stage.

Alaska Packers Ass'n v. Domenico, 117 F. 99 (9th Cir. 1902).

B. Conditional Spending Concepts Reflect Contract Formation Principles

The paradigmatic spending-power circumstance is that of a state seeking out federal funding – *i.e.*, contract formation. States voluntarily and knowingly take affirmative steps to apply for federal funds. That voluntary and knowing decision is protected by Pennhurst's "clear notice" rule, which requires conditions on spending be stated unambiguously and made known to states in advance of their decision to enter into and accept the conditions attached to a federal spending program.

The Court of Appeals erred by applying the "clear notice" rule not to contract formation but to contract modification – finding that notice of PPACA's changes satisfied Pennhurst's clear-notice rule. Subject to certain qualifications, *infra*, the clear-notice rule applies at the contract-formation stage, when states decide whether or not to enter into a federal spending program. See I. Glenn Cohen & James F. Blumstein, *The Constitutionality of the ACA's Medicaid-Expansion Mandate*, NEW ENG. J. MED. (Online First Dec. 7, 2011), available at http://www.nejm.org/doi/full/10.1056/NEJMp1113416 [Cohen & Blumstein].

Contract modification poses much thornier problems. The federal-state contract already exists, as in Medicaid, and is ongoing. Unilateral federal modification, when linked to and made a condition for maintaining that pre-existing contract as under PPACA, deprives states of their freedom not to act.

Contract modification fundamentally alters the spending-clause paradigm. States cannot just decline to seek out an opportunity – to seek out a carrot. They must act affirmatively to departicipate from an ongoing, pre-existing contractual relationship if the new conditions make the pre-existing program unattractive from a state's perspective. Arlington, 548 U.S. at 298 (state's perspective is key).

At contract formation, doctrinal *laissez faire* retains state autonomy, but not so at contract modification. Contract rules regarding contract modification call for more intense scrutiny and oversight, reflecting this concern about changed circumstances and detrimental reliance that can result in excessive leveraging (as in the case of PPACA). The owner of the fishing vessel is compromised once the ship is out at sea in a way it is not before the ship sets sail.

C. Cooperative Federalism Contracts Reflect Ongoing Relationships

Cooperative federalism programs like Medicaid have an ongoing character and "cannot be viewed in the same manner as a bilateral contract governing a discrete transaction." Bennett v. Kentucky Dept of Educ., 470 U.S. 656, 669 (1985) [Kentucky]. In contractual terms, they are – or are analogous to –

relational contracts.[4] The terms of relational contracts are not set in stone when the contract is formed. The parties are involved in a complex set of interactions that make it difficult to ascertain future contingencies or allocate risks at the time of contracting.[5] Relational contracts, therefore, assume that modifications to a contract may be made over time, as circumstances change.[6]

The federal-state contract is formed when states agree to participate in the program. The ongoing nature of the relationship contemplates interpretation and "[g]iven the structure of the grant program, the Federal Government simply could not prospectively resolve every possible ambiguity concerning particular applications of [federal] requirements." Id. That is, the relational nature of the contract means that some ambiguity must be tolerated.

But in important ways this Court has constrained federal authority to interpret the post-acceptance terms of these relationship-driven contracts and thereby modify the contractual terms and conditions.

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[4] For discussions of relational contracts in the commercial context, see Richard E. Speidel, The Characteristics and Challenges of Relational Contracts, 94 NW. U. L. REV. 823, 828 (2000); Ian R. MacNeil, Values in Contract: Internal and External, 78 NW. U. L. REV. 340, 361 (1983).

[5] Charles J. Goetz & Robert E. Scott, Principles of Relational Contracts, 67 VA. L. REV. 1089, 1090 (1981).

[6] Gordon, 1985 WIS. L. REV. at 569 (relational contracts "are not frozen at the initial moment of commitment, but change as circumstances change...").

In Kentucky, the Court refused to apply a deferential arbitrariness standard to federal interpretations – the normal administrative law standard. Instead, federal interpretation must "be informed by the statutory provisions, regulations, and other guidelines provided by" the federal government "when the State agreed to comply" with federal terms and conditions – namely, at the time that the "grants were made." Post-acceptance federal interpretations of terms and conditions are constrained by the "legal requirements in place" at the contract-formation stage. Id. at 670.

The nature of an ongoing federal-state relational contract allows some flexibility in the administration of that contract, but that flexibility does not allow the federal government to redo willy nilly the terms of the contract when entered into. The terms at contract formation govern. Reasonable implied terms of the original contract are acceptable as binding, Barnes, 536 U.S. at 188, but the rule is that states' "obligations generally should be determined by reference to the law in effect when the grants were made." Bennett v. New Jersey, 470 U.S. 632, 638 (1985). Subsequently enacted legislative amendments "do not affect obligations under previously made grants." Id. at 637. If states must re-apply for funds through an affirmative application process – a contract-formation situation –, then the obligations in effect at that point govern the new contract. But where the contract is ongoing, as in Medicaid, the states' obligations are governed by the terms and conditions in effect at the time the state agreed to participate.

II. Factual Background and Implications

Medicaid was enacted in 1965 under the Social Security Act to provide medical assistance for qualified low-income persons. See Robert Stevens & Rosemary Stevens, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974)(describing early experience under Medicaid). "Historically, medical support programs have tended to follow and to be built upon government's income maintenance initiatives." Clark C. Havighurst et al., Strategies in Underwriting the Costs of Catastrophic Disease, 40 LAW & CONTEMP. PROBS. 122, 183 (1976). That was the case with Medicaid and Medicare, both of which "built upon pre-existing programs of income support and, categorically, relied upon the definition of eligibility in those foundational income maintenance entitlements" – Social Security for Medicare and Aid to Families with Dependent Children (AFDC, later Temporary Assistance for Needy Families or TANF) for Medicaid. James F. Blumstein & Frank A. Sloan, Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm, 53 VAND. L. REV. 125, 136-37 & n.32 (2000)[Blumstein & Sloan]. States have had flexibility to set income standards under TANF; not all adults with poverty-level incomes must be eligible for TANF or Medicaid.

Under Medicaid, federal dollars match qualified state expenditures based on a formula. Traditionally, the federal government has set floors and ceilings on such matters as beneficiary eligibility and available services. States have had "the authority to add beneficiaries... and to add services, within program constraints imposed by the federal government." Id. at 138 & n.38. All states have chosen to sign up for

Medicaid, id. at n.37, which is a constitutionally-protected voluntary choice by states. Printz, 521 U.S. at 925.

Typically, Medicaid constitutes one of a state's two most expensive programs – the other being K-12 education. In Tennessee, for example, the Medicaid budget nearly tripled from 1987-93, expanding to over 25% of the state's budget and precipitating Tennessee's TennCare program in 1994 (a Medicaid managed care program). Blumstein & Sloan, at 150 & n.82.

PPACA aims to cover over 30 million previously medically uninsured persons. Over half of these additional insureds are projected to come from the expanded Medicaid mandate imposed on states: Effective January 1, 2014, states must cover all persons, including adults, with incomes under 133% of poverty under Medicaid[7] or take steps affirmatively to opt out of Medicaid entirely.[8]

In effect, PPACA terminates traditional Medicaid as conventionally understood. But it achieves that outcome without formally terminating the program and states' obligations thereunder – choosing instead to retain the structure and modifying Medicaid's terms unilaterally.

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[7] This rises to 138% of poverty when an income-disregard provision is taken into account. See Florida Brief at 7.

[8] Mandating coverage of persons with incomes under 133% of poverty eliminates an essential ingredient of traditional Medicaid – flexibility for states to determine levels of income eligibility. See Cohen & Blumstein.

Instead of recreating a contract-formation situation by legislating the end of traditional Medicaid or by allowing states to opt in to the new conditions independently as a matter of contract formation, PPACA thrusts the political onus for acknowledging and/or managing the new reality, legislated by the federal government, on the states. And the choices to which states are put infringe on their constitutionally-protected autonomy.

Under PPACA, a state cannot retain its traditional Medicaid program since that program ceases to exist in 2014 by dint of federal legislation. The status quo is not an option.

State inaction without adverse consequences, the contract paradigm of spending-power cases at contract formation, is not an option. In the face of PPACA, states face coercive choices to which they may not be put by the federal government.

At contract formation, if a state chooses not to sign-up for a federal spending program, it does not benefit from federal funding, but otherwise no adverse consequences exist compared to the status quo. States' inaction – the true measure of their political autonomy – results in no program enhancements from particpating in a federal program, but leaves them no worse off. It reflects no more than failing to eat a carrot. But in the context of the unilateral contract modification imposed by PPACA, state inaction without consequences is not an option.

State inaction leaves in place pre-existing Medicaid obligations unless and until repealed. But PPACA eliminates federal matching support for pre-existing

Medicaid *in toto*, so states' inaction means that their care obligations under pre-existing Medicaid remain and, fiscally, automatically increase from a fraction of the total cost (between one-sixth and one-half) to 100% of the total cost of a program that on average already absorbs 20% of state budgets.

So, unlike the contract-formation context, PPACA's leveraging on pre-existing Medicaid contracts makes state inaction without consequences impossible. The result of state inaction is the never-contemplated provision of medical care to previously eligible Medicaid beneficiaries entirely at state expense. This is no longer a failure to eat a carrot but being sanctioned fiscally and coercively with a big stick.

Inaction without consequences not being an option, states are forced to act affirmatively. They have two choices: act to embrace the new conditions or act to departicipate from Medicaid. Neither option respects state autonomy by respecting states' rights not to act without consequences.

States can act affirmatively to departicipate from Medicaid, but that puts the political onus not only to act but also to take political accountability for an action not of the states' doing. The federal government, not the states, decided to terminate traditional Medicaid and not offer states the option of accepting or rejecting the new terms through a discrete opt-in approach, whereas the states are obliged to take political heartburn for action they did not initiate or control. *Cf.* Printz, 521 U.S. at 930 (noting accountability problem when states "are… put in the position of taking the blame" for burdensome federal actions).

Alternatively, states can accept PPACA's new conditions and thereby accept the additional fiscal obligations. While that opportunity might be appropriate in the context of contract formation – when states could choose to secure the benefits of PPACA and shoulder the fiscal burdens as well --, it is inappropriate at contract modification when failure to act is not status-quo-neutral but has dire and impermissible consequences. This set of choices, therefore, is coercive, beyond what the federal government can impose on states.

In short, this is not a case of a state declining to apply for a federal grant through inaction at the contract-formation stage. To decline the terms of PPACA's New Medicaid (or Medicaid 2.0), states cannot remain passive. They must act to undo existing Medicaid legislation. This is not the same as deciding, at contract formation, whether or not to participate in Medicaid. This is the kind of unforeseeable, coerced action states are protected against under the anti-commandeering principle.

Under PPACA, the other half of newly-covered insureds (non-Medicaid) are to receive medical insurance through newly-enacted state-based exchanges. The purchase of such insurance is mandated. Persons with incomes in the 100%-400% of poverty range receive federal subsidies.

Strikingly, persons with incomes under 100% of poverty do not qualify for federal subsidy on these exchanges. This is telling, coming as it does in major legislation designed to achieve "near-universal" coverage of the uninsured. See Florida Brief at 6. This omission is a clear demonstration that the expanded

Medicaid coverage is not contemplated as a voluntary choice by states -- free to choose whether or not to act affirmatively to participate in Medicaid.

The expanded Medicaid-coverage mandate is part of the very architecture of PPACA.

There is no federal contemplation that states have a realistic choice to exit Medicaid, thereby leaving uncovered the poorest and most vulnerable of a state's residents (who had previously been covered), while the near-poor receive newly-enacted federal subsidies. Leveraging of an already-existing relationship is the name of the PPACA enterprise, with states treated as cash cows offsetting what would otherwise be federal obligations to achieve PPACA's access objectives.

Leveraging existing contractual relationships is built-in to the DNA of PPACA; the very structure of PPACA would be unthinkable to the architects of PPACA if real choice of exit from Medicaid existed, since that would mean no federal subsidy for those with incomes under 100% of poverty while those with incomes in the 100%-400% of poverty range would receive federal subsidy on the state-based exchanges. Such an outcome would be utterly irrational.

This is not a news flash. The point is expressly conceded in proposed regulations to implement the subsidies (the "premium tax credit") on the exchanges. The IRS matter-of-factly notes that "[t]axpayers with household incomes below 100 percent" of poverty "are not eligible for the premium tax credit **because** they are eligible to receive assistance through Medicaid." Internal Revenue Service, Health Insurance Premium Tax Credit Notice of Proposed Rulemaking, 76 Fed.

Reg. 50931, at 50934 (August 17, 2011)(emphasis supplied). A clearer acknowledgment of the understanding that states cannot and are not contemplated to opt out is hard to imagine.

To summarize: PPACA is a form of contract modification, using leverage coercively from an already-existing relationship to add more onerous terms and conditions to that pre-existing relationship. State non-compliance cannot be achieved by inaction – *e.g.*, by not applying for funds at the contract formation stage. State non-compliance with PPACA requires states to act affirmatively to undo an existing and ongoing relationship. Notice to states at PPACA's contract-modification stage does not protect states' autonomy interests in making an informed choice to determine whether or not to enter the Medicaid contract at the outset. States are only provided notice of the opportunity to act affirmatively to exit the traditional Medicaid program; that does not substitute for a requirement that state decisionmaking be unambiguously informed at the time states determine to accept the terms and conditions of Medicaid at the contract-formation stage.

III. The Constitutional Framework of Federalism: Anti-commandeering, Clear Notice, and Coercion

Federal power is limited in two ways: (i) lack of a source of authority (as in the challenge to PPACA's Individual Mandate) or (ii) violation of an affirmative limitation on federal power. The federal government "exercises its conferred powers" -- here its spending power – "subject to the limitations contained in the Constitution." New York, 505 U.S. at 156.

Pennhurst, as reaffirmed by South Dakota v. Dole, 483 U.S. at 207, gave effect to states' reserved constitutional authority not to exercise their sovereign powers by adopting a "clear notice" rule that protects state decisionmaking autonomy and integrity. These two related, constitutionally-based principles – anti-commandeering and clear notice – are at the heart of the limitations on federal spending power in this case.

PPACA's expanded Medicaid mandate (i) violates Pennhurst's clear-notice rule – an affirmative limitation on federal power – and is (ii) unconstitutionally coercive in violation of the anti-commandeering doctrine.

A. Anti-commandeering and Coercion

One constitutional limitation on federal power is that the federal government "may not simply 'commandeer the legislative processes of the States by directly compelling them to enact and enforce'" a federal program. Id. at 161 (internal cite omitted). The decision to enter into a federal cooperative federalism program like Medicaid is a constitutionally-protected state choice. It can be encouraged by financial incentives, but it may not be coerced, id. 166-67, as that would violate an attribute of state sovereignty. Printz, 521 U.S. at 928.

Pennhurst, 451 U.S. at 17, observed that the very "legitimacy" of federal spending-power programs turns on states' authority to decide whether to participate or not. This recognizes the anti-commandeering principle, which was embraced in the spending-power context before it was refined in the regulatory context.

The limit against "coercion" in federal-spending cases indicates that anti-commandeering has a functional dimension in conditional-spending cases that is a counterpart to its more formalistic sibling in the regulatory context.

Anti-commandeering principles protect state sovereignty interests against the "compelled exercise of... sovereign powers." FERC v. Mississippi, 456 U.S. 742, 769 (1982). Such sovereign powers include "promulgat[ing] and enforc[ing] laws and regulations." Id. at 762. Since states cannot be compelled to exercise their sovereign powers, they retain the sovereign right to inaction without adverse consequences as compared with the status quo. A right not to be compelled to act is a protected right not to act. *See* New York, 505 U.S. at 175 (states' right of inaction regarding federally-imposed take-title provision is constitutionally protected against coercion under anti-commandeering principle).

This paradigm works well in the spending-power context as applied to contract formation. A state's refusal to sign-up for a federal spending program is consistent with state sovereign interests in non-action. A state, fully informed in advance of the conditions attached to a federal program, can make a choice: Participate, enjoy the benefits of the program, and endure the costs; or not participate with no adverse effects as compared to the status quo ante.

Contract modification is an altogether different circumstance. States already have an ongoing, pre-existing contractual relationship with the federal government. Contract law dictates careful scrutiny of contract modifications because of the risk of excessive/predatory leveraging, opportunistic behavior that can threaten to undermine the basis of the initial contract and, in the context of federalism, undermine states' sovereign interests in non-action without adverse consequences.

B. The Clear-Notice Doctrine

The Pennhurst "clear notice" principle is also of constitutional dimension. It assures that, when states agree to enter into a federal-state contract by participating in a cooperative federalism program like Medicaid, they are acting "voluntarily" and with "knowing acceptance" of the terms of the "contract," 451 U.S. at 17, exercising an "informed choice" that safeguards them from being surprised by imposition of "postacceptance or 'retroactive' conditions." Id. at 25.

The clear-notice rule has both positive and negative characteristics.

Positively, it protects the integrity of state decisionmaking by guaranteeing that states have full and unambiguous disclosure of what is expected of them, of what burdens they are undertaking, at the relevant time in the decisionmaking process – before they embark on the slippery slope by committing to participation in a cooperative federalism program.

Negatively, it is a rule against *ex post* blind-siding, against "surprising participating states with postacceptance or 'retroactive' conditions." Id. As a matter of federalism, Pennhurst's clear-notice doctrine protects states against federal bait-and-switch tactics – after-the-fact imposition of conditions on federal spending programs. Conditions in effect at the time of a grant – not subsequently enacted rules – apply so as to spare states from unclear obligations assumed at the time that states choose to participate in a cooperative federalism program.

Pennhurst's clear-notice rule must be understood in the context of the attribute of state sovereignty embodied by the anti-commandeering principle.

The clear-notice rule is constitutionally-derived in character, protecting states' constitutional ability, under anti-commandeering principles, to refrain from participating in cooperative federalism programs. The clear-notice rule protects a state's autonomy to determine, voluntarily and knowingly, whether or not to agree to receive financial benefits in exchange for relinquishing its sovereign power to resist mandatory imposition of federal authority. The clear-notice rule is analogous to other constitutional doctrines – *e.g.*, freedom of association (NAACP v. Alabama, 357 U.S. 449 (1958)), criminal-defendant warnings (Dickerson v. United States, 530 U.S. 428 (2000)), campaign spending (Citizens United v. FEC, 130 S. Ct. 876 (2010)), or state sovereign immunity (Alden v. Maine, 527 U.S. 706 (1999)) – that have developed to protect underlying constitutional principles. See Griswold v. Connecticut, 381 U.S. 479, 483-84 (1965)(characterizing these as "peripheral" rights, distinct from now-discredited "penumbral" rights, which evolve from but are distinct and freestanding from the underlying constitutional norms).

The essence of Pennhurst's clear-notice rule is that notice is given in advance – allowing states and their decisionmakers to make informed choices about accepting conditions on federal funding that states cannot otherwise be compelled to accept. A recipient of federal funding must be "*on notice* that, by accepting federal funding, it exposes itself" to the condition-on-spending at issue. Barnes, 536 U.S. at 187(emphasis in original).

The issue is viewed "from the perspective of a state official who is engaged in the process of deciding whether the State should accept [federal] funds and the obligations that go with those funds." Does the federal program provide "clear notice" regarding the scope of a state's obligations? Would the state and its officials "clearly understand" the conditions that attach to a state's decision to enter into a cooperative federalism contract? Arlington, 548 U.S. at 298.

Through advance notice to state decisionmakers at contract formation, the clear-notice rule protects a state's constitutionally-derived authority to make "an informed choice," Pennhurst, 451 U.S. at 25, when it chooses to enter into a federal-state contract and accepts federal funding. The federal government may not "surpris[e] participating States with postacceptance or 'retroactive' conditions." Id. The clear-notice rule protects a state's right not to enter into or "implement" Medicaid – *i.e.*, not to form a federal-state contract. Printz, 521 U.S. at 925; New York, 505 U.S. at 176.

The clear-notice rule is not satisfied when states are lured into a federal—state relationship on one set of expectations and then informed that, through contract modification, the fiscal implications of remaining in the program have been substantially and unforeseeably ratcheted up. Providing states with notice of their right of "exit" from an ongoing relationship that has already been formed – mandating affirmative enactment of state legislation to exit the federal-state program – is not a substitute for enabling states to "exercise their choice" of entering into a federal-state contract "cognizant of the consequences of their participation," Pennhurst, 451 U.S. at 17, and thereby "knowingly undertak[ing]" an obligation based on an "informed choice." Id. at 25.

IV. Structural Characteristics of Cooperative Federalism Programs Require the Clear-Notice Rule to Apply at the Contract-Formation Stage

A. Benefits to States

Federal-state matching programs provide benefits to states.

Federal funding enhances programmatic choices/options for states – benefits and resources that transcend what states can afford on their own. There is also a "bitter-with-the-sweet" dimension: States must accept federal terms and conditions attached to receipt of federal funds. The clear-notice rule is designed to safeguard and inform the constitutionally-protected state decisionmaking process of determining whether to enter the federal-state program (contract formation) – fully understanding in advance the bitter as well as the sweet.

B. Risks to States and the Federal Government

Risks also arise from cooperative federalism programs. Political accountability is displaced.

Because of Medicaid's automatic federal matching feature, state decisionmaking drives the federal budget when states expand program expenditures (which are matched with federal dollars). Once states enter a service-benefit program like Medicaid and become locked-in, the federal government can use its intense leverage (at contract modification) to drive state budgets by mandatorily increasing states' expenditures. This is the PPACA scenario and strategy. See generally Blumstein & Sloan, at 136-49; David Freeman Engstrom, Drawing Lines Between *Chevron* and *Pennhurst*: A Functional Analysis of the Spending Power, Federalism, and the Administrative State, 82 TEX. L. REV. 1197, 1239-52 (2004).

1. Political Moral Hazard

The very design of federal matching programs provides "a powerful incentive for States to expand their Medicaid programs, possibly at the expense of programs that might have a higher state or local priority, but which would have to be funded entirely by state or local funds and therefore get 'crowded out.'" Blumstein & Sloan, at 139. Through a form of fiscal novocaine, federal matching anesthetizes political constraints that restrain growth of state spending/benefits programs, creating a form of political "moral hazard" that "encourag[es] states to adopt and finance programs... that are 'worth' (depending on the applicable matching rate) $.17-$.50 on the dollar to the politically accountable decisionmaking entity – the state." Id. at 139-40 & n.45. It is "economically and politically rational to spend state funds that, were the state paying the full bill, might not comport with state priorities." Id. at 140.

Sometimes, a good deal may be good but unaffordable. Consider whether to accept a gift from Bill Gates – a $30+ million home with 25,000+ square feet – on condition that the recipient pay property taxes, insurance, and general upkeep expenses. Sounds like a good deal, but it may be unaffordable because of the fiscal "co-pay."

The clear-notice rule protects the integrity of a state's political process. "[T]he allocation of scarce resources among competing needs and interests lies at the heart of the political process." Alden v. Maine, 527 U.S. at 751. Excessive federal leverage over states may distort a state's political process by disadvantaging other potential claimants on state resources and may even threaten states' financial integrity, creating "staggering burdens" on them and giving the federal government "leverage" over the states that is "not contemplated by our constitutional design." Id. at 750 (discussing abrogation of states' sovereign immunity).

Requiring that state decisionmakers know unambiguously and in advance what fiscal consequences stem from assuming an obligation in a cooperative federalism program protects state autonomy by assuring informed decisionmaking. By analogy to procedural due process, notice/disclosure must come "at a meaningful time and in a meaningful manner." Fuentes, 407 U.S. at 80 (internal cite omitted). To fulfill that goal, notice/disclosure must come at the strategic time – when states decide to participate in a cooperative federalism program, knowingly and voluntarily accepting its conditions. That time is at the contract-formation stage.

2. Lock-in

The leveraging from federal matching creates a strong incentive for program expenditure expansion. This creates political dependence – a "political addiction" that locks-in cooperative federalism programs and makes cutbacks painful. "To save a state-generated Medicaid dollar, a state must reduce program expenditures by anywhere from two to six dollars (depending on the federal matching formula for a given state)." Blumstein & Sloan, at 142.[9]

The lock-in phenomenon – the fishing vessel out at sea – is exacerbated by (i) state investments in administrative infrastructure, which build in costs and generate reliance[10] and (ii) the nurturance of political constituencies – beneficiaries and providers – that resist program cutbacks or elimination.[11] Engstrom, 82 TEX. L. REV. at 1243-44. This threat of lock-in and the impact of reliance suggest that federal imposition of additional substantial, unforeseeable, and onerous conditions provides excessive/predatory leveraging. Id.

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[9] Political moral hazard has much in common with the problem of slippery-slope decisionmaking. A slippery slope is a situation "where decision A, which you might find appealing, ends up materially increasing the probability that others will bring about decision B, which you oppose." Eugene Volokh, The Mechanisms of the Slippery Slope, 116 HARV. L. REV. 1026, 1030 (2003). To be effective, the clear-notice duty in the context of cooperative federalism programs must attach prior to a state's "decision A" – *i.e.*, at contract formation -- not at its "decision B" (whether to opt out of substantial and unforeseeable mid-stream contract modifications).

[10] The kind of state reliance that accrues from ongoing participation in cooperative federalism programs is analogous to the life-choice reliance regarding abortion described in Planned Parenthood v. Casey, 505 U.S. 833, 856 (1992)(plurality): "[F]or two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail. The ability of women to participate equally in the

In contract terms, deference to the use of contract modification of an ongoing contractual relationship is unwarranted, unlike deference shown at the contract-formation stage. If "lock-in effects are substantial," then the federal government can "enter into broad agreements with states, wait for lock-in, and then…

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economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." Reliance can stem from decisions that are based on a certain set of expectations that influence how people "order[] their thinking and living." This explains that states' decisionmaking processes are affected differently by a decision to participate in a federal-state program (contract formation) and a decision to act affirmatively to exit from that program in the face of the imposition of additional fiscal conditions (contract modification as under PPACA). Analogy of state autonomy interests, such as the anti-commandeering principle, to similar individual-oriented rights is appropriate. For example, in College Savings Bank v. Florida Prepaid Postsecondary Educ. Expense Bd., 527 U.S. 666, 682 (1999), the Court rejected a claim of implied waiver of a state's sovereign immunity, noting that "'[c]ourts indulge every reasonable presumption against waiver' of fundamental constitutional rights" (internal cite omitted). The analogy to waiver of individual constitutional rights was explicit: "State sovereign immunity, no less than the right to trial by jury in criminal cases, is constitutionally protected." Id.

[11] Support for provider infrastructure is an important goal of Medicare and Medicaid. Fischer v. U.S., 529 U.S. 667, 679-80 (2000).

extract more onerous conditions than could have been imposed at the moment the deal was struck." Id. at 1244.

The Pennhurst clear-notice rule protects states from these coercive federal leveraging strategies. It enables states to make their "choice [not to participate in a federal-state spending program] knowingly, cognizant of the consequences of their participation." 451 U.S. at 17. The states' choice to participate must be an "informed choice" that provides "clear notice" of what is expected, not "surprising participating States with postacceptance or 'retroactive' conditions." Id. at 25. States must be *"on notice,"* Barnes, 536 U.S. at 187(emphasis in original), of what is expected of them when they agree to participate in a federal spending program, with the relevant perspective that of a state official "engaged in the process of deciding" whether to enter into a federal-state contract with its attendant conditions. Arlington, 548 U.S. at 296. To achieve these goals, the clear-notice obligation must apply at the contract-formation, not the contract-modification, stage.[12]

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[12] The implications of earlier decisions in influencing subsequent decisions are recognized in the literature of "path dependence." *Cf.* Oona A. Hathaway, Path Dependence in the Law: The Course and Pattern of Legal Change in a Common Law System, 86 IOWA L. REV. 601 (2001). In order to make informed choices, states must be clearly informed at the initial decisionmaking stage (contract formation) not when a subsequent, substantial and unforeseeable change of conditions is made (contract modification).

V. Application of Analysis and Remedy

A. Coercion

The lower courts have had a hard time applying the functional anti-commandeering principle of coercion in the conditional spending context. The reason is they have misperceived the nature of the inquiry.

A common view of coercion is process-focused – a police officer beating a confession from a criminal defendant. That process-focused model does not transfer easily to the context of conditional spending.

But there is a different model that does apply –"choice-set" coercion.

Lee v. Weisman, 505 U.S. 577, 594-96 (1992), an Establishment Clause case, exemplifies "choice-set" coercion. A student objected to a religious message at her graduation, claiming it to be coercive. The government defended on the ground that attendance at graduation was voluntary; no coercion existed because the student could stay home without penalty.

This Court disagreed, holding that government could not force a choice between voluntary non-attendance at graduation so as to avoid a religious message and "forfeiture" of the intangible benefits from attending graduation; *accord*, Santa Fe Independent School Dist. v. Doe, 530 U.S. 290, 312 (2000)(same regarding choice not to attend high school football games or be subject to religious message).

Here, the context is contract modification, not contract formation. The opportunity for excessive, predatory leverage exists, and exists regarding PPACA.

States cannot retain their sovereign right of non-action. To avoid the expanded Medicaid obligations of PPACA, a state must act affirmatively – to opt out of Medicaid entirely. That action forces states to undo an existing contract when it is the federal government that has in effect undone that contract by modifying its terms in ways that were unforeseeable when entered into. Exercise of a state's right of non-action breeds fiscal disaster, as states must provide Medicaid to beneficiaries entirely at state expense and without federal matching funds.

Moreover, PPACA makes this state choice politically poisonous by linking the new conditions to retention of pre-existing contractual benefits and, by not subsidizing persons with incomes below 100% of poverty while newly subsidizing persons with incomes in the 100%-400% of poverty range, forcing an odious choice that cannot exist at contract formation.

Because of the structure of the program adopted by the federal government, and the federal government's foisting off on states the political accountability for a choice not of the states' making, this type of choice improperly impairs states' decisionmaking autonomy.

As the federal government has admitted, 76 Fed. Reg. at 50934, the very architecture of PPACA, which is designed to achieve near-universal medical insurance coverage, contemplates that states have no choice but to embrace Medicaid 2.0: "Taxpayers with household incomes below 100 perrcent" of poverty "are not eligible for the premium tax credit" provided to persons with incomes in the 100%-400% range "because they are eligible to receive assistance through Medicaid." That is not happenstance but part of the very design or DNA of PPACA.

At contract modification, this is exactly the type of excessive, predatory leveraging that contract doctrine guards against (recall the fishing vessel case) and that is impermissibly coercive.

Alternatively, states can act to accept the new Medicaid terms, but that decision is hardly the type of dcisionmaking context that the spending-power cases contemplate – wherein states face no adverse consequences compared to the status quo from a decision not to participate.

The states' decision to accept PPACA's new terms at contract modification puts states in a position of having been blind-sided with conditions that they did not and could not anticipate at contract formation – suffering precisely the kind of bait-and-switch after-the-fact blind-siding that Pennhurst guards against. 451 U.S. at 25 ("Congress' power to legislate under the spending power ... does not include surprising participating States with posacceptance or 'retroactive' conditions").

B. The Clear-Notice Principle and Contract Modification

The federal-state Medicaid contract was formed when states agreed to participate in the program. Given the substantial fiscal impact on states and unforeseeable nature of PPACA's modifications, the

Pennhurst clear-notice obligation must attach at contract formation, not contract modification.

The ongoing nature of the Medicaid relationship contemplates contract interpretation. The relational nature of the contract means that some ambiguity must be tolerated. That does not conflict with Pennhurst's clear-notice principle. Kentucky, 470 U.S. at 669.

But federal interpretation of ambiguity must be within the framework of the terms/conditions of the contract at the contract-formation stage. Post-acceptance federal interpretations of terms and conditions are constrained by the "legal requirements in place" at the contract-formation stage. Id. at 670.

Reasonable implied terms of the original contract are acceptable as binding, Barnes, 536 U.S. at 188, but states' "obligations generally should be determined by reference to the law in effect when the grants were made." Bennett v. New Jersey, 470 U.S. 632, 638 (1985). Subsequently enacted legislative amendments "do not affect obligations under previously made grants." Id. at 637. The terms at contract formation govern.

Not all contract modifications in ongoing, relational contracts are problematic, but modifications such as PPACA that rely on excessive/predatory leveraging are. See Muris, 65 MINN. L. REV. at 538 (The issue is "whether the modification was extorted").

The critical objective of Pennhurst's clear-notice rule is to safeguard states' ability to enter into federal-state spending programs knowingly and voluntarily so as to protect their autonomy and the integrity of their political process. When additional substantial, unforeseeable, expensive, and mandatory conditions/obligations are imposed mid-stream via contract modification, states' constitutionally-protected interests are at stake. States' ability to exit a contractual relationship at the time of contract modification is hardly to be equated with the sovereign interests protected by Pennhurst's clear-notice rule – to be put on notice in advance of the financial and political consequences of voluntarily agreeing to accept federal funding.

To accommodate the contract-law principle and, as a practical matter, a limiting principle should apply to the overall proposition that the Pennhurst clear-notice rule applies at the contract-formation stage of an ongoing, cooperative federalism program. Whatever reasonable limiting principles that are established will be satisfied by the federal leveraging action reflected in PPACA.

While subsequent cases will have to draw the lines, I propose the following standard to govern PPACA and similar ongoing cooperative federalism programs: Providing clear notice of substantial, mandatory changes to Medicaid, as effected by PPACA, does not satisfy the federal government's clear-notice obligation when those modifications (i) are substantial and unforeseeable at the sign-up stage, (ii) have a significant fiscal impact on state-administered programs, and (iii) comprise a substantial component of a state's overall budget (as Medicaid does). *Cf.* Cohen & Blumstein.

States cannot be bound by PPACA's expanded Medicaid mandate because the federal government failed to satisfy Pennhurst's clear-notice rule when states signed-up for Medicaid (at the contract-formation stage). PPACA's changes to Medicaid are substantial, were unforeseeable at contract formation, and occur at contract modification. They have a significant fiscal impact on the already-existing Medicaid program, and Medicaid comprises a substantial component of a state's overall budget. Under the circumstances, a substantial modification of the Medicaid contract (as embodied in PPACA) cannot be used as an end-run around the federal government's obligation to provide states with clear and timely notice of what participation in Medicaid entails budgetarily.

C. What the Federal Government Must Do

The federal government has sovereign interests in not maintaining a program it wishes to terminate. If the federal government wishes to discontinue traditional Medicaid in favor of a new flavor (PPACA's New Medicaid), it can do that. But it must achieve that goal by re-creating a contract-formation situation and providing states with a clear, unambiguous statement of their financial obligations if they choose to participate in New Medicaid.

One option would treat PPACA's new conditions as contract formation, allowing states to opt in or not, fully informed in advance, without adverse consequences as compared to the status quo ante. That would decouple New Medicaid from traditional Medicaid, allowing states to retain their participation in the ongoing contractual relationship.

If the federal government chooses to require states either to accept or reject New Medicaid entirely – and to disallow states to continue their participation in traditional Medicaid – the federal government can do that. But it must shoulder the political burden and accept the political accountability for that action – for precluding states from their continued participation in traditional Medicaid. *Cf.* Printz, 521 U.S. at 930 (noting accountability problem when states "are… put in the position of taking the blame" for burdensome federal actions). The federal government must terminate traditional Medicaid and its legal infrastructure, not put the onus on states to act affirmatively to exit Medicaid in the face of contract modification.

States need not opt out of or exit traditional Medicaid since it would no longer exist by federal action. That would re-create a contract-formation situation. The federal government would be required at the contract-formation stage to state clearly the conditions of state participation in New Medicaid. States could then determine knowingly and voluntarily whether or not to participate in New Medicaid. They could opt in to New Medicaid, being on notice in advance of the fiscal consequences and making a fully informed choice, for which they would be accountable politically.

This approach aligns political accountability, an objective of the anti-commandeering principle, New York, 505 U.S. at 168-69, and protects states' autonomy against excessive/predatory federal strategic leveraging via contract modification. There is federal responsibility for terminating traditional Medicaid, for withdrawing states' ability to retain benefits under their traditional Medicaid programs, and for creating New Medicaid with its attendant opportunities and obligations. Correspondingly, there is state responsibility for determining, voluntarily and knowingly, whether or not to accept the bitter-with-the-sweet of New Medicaid, on notice, in advance and with a clear understanding of what is at stake.

State inaction would result in non-acceptance of New Medicaid at the contract-formation stage (and without consequences compared to the status quo). States would not be forced to act in order to exit an existing, ongoing program because of a substantial program modification at the contract-modification stage.

The result is that PPACA's expanded Medicaid mandate cannot bind states in its present form.

CONCLUSION

For the foregoing reasons, the Court of Appeals decision regarding PPACA's expanded Medicaid mandate should be reversed.

Respectfully submitted,

James F. Blumstein
Counsel of Record
University Professor of Constitutional Law
and Health Law and Policy
Vanderbilt Law School
131 21st Avenue South
Nashville, TN 37203
Telephone: 615-322-3710
Facsimile: 615-322-6631
Email: James.Blumstein@Vanderbilt.edu

Counsel for *Amicus Curiae*
James F. Blumstein

January 17, 2012

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James F. Blumstein serves as University Professor of Constitutional Law and Health Law and Policy at Vanderbilt Law School and Vanderbilt University Medical School and as Director of the Vanderbilt Health Policy Center. He also serves as Adjunct Professor of Health Law at Dartmouth Medical School and, in 2010-11, served as inaugural Scholar-in-Residence at the Robert Wood Johnson Health Policy Center at Meharry Medical College. He serves on the National Advisory Board of the Robert Wood Johnson Health Policy Center at Meharry Medical College.

Professor Blumstein has served as Visiting Associate Professor of Law and Policy Sciences at Duke Law School and the Duke Institute for Policy Sciences and Public Affairs, and John M. Olin Visiting Professor of Law at the University of Pennsylvania Law School. He has been an active teacher and scholar in the field of health law and policy and co-editor with Clark C. Havighurst and Troyen A. Brennan of HEALTH CARE LAW AND POLICY (2d ed. 1998 and 2007 Supp. Foundation Press). Professor Blumstein is an elected member of the Institute of Medicine of the National Academy of Sciences and has served as Chair of the Section of Law, Medicine, and Health Care of the Association of American Law Schools.

In 1990, Professor Blumstein was nominated by President George H. W. Bush (R) to serve as Administrator of the Office of Information and Regulatory Affairs (OIRA) of the Office of Management and Budget. During 2004-07, Professor Blumstein served as retained counsel to Tennessee Governor

Philip N. Bredesen (D) during Governor Bredesen's TennCare reform initiative. TennCare is Tennessee's Medicaid demonstration program. At the invitation of the Tennessee Court of Appeals, Professor Blumstein served as *amicus curiae* in a then-pending TennCare matter. Tennessee *ex rel.* Pope v. Xantus Healthplan, 2000 Tenn. App. LEXIS 319, at *5, n.2.

In this brief, Professor Blumstein speaks for himself, not for any of his institutional affiliations.

AMICUS CURIAE BRIEF

Nos. 11-393 & 11-400

In The
Supreme Court of the United States

◆

NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, *et al.*,

Petitioners,

v.

KATHLEEN SEBELIUS,
Secretary of Health and Human Services, *et al.*,

Respondents.

◆

STATE OF FLORIDA, *et al.*,

Petitioners,

v.

DEPARTMENT OF HEALTH
AND HUMAN SERVICES, *et al.*,

Respondents.

◆

**On Writ Of Certiorari To The
United States Court Of Appeals
For The Eleventh Circuit**

◆

BRIEF FOR THE STATES OF CALIFORNIA, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, MARYLAND, NEW MEXICO, NEW YORK, OREGON, AND VERMONT, THE DISTRICT OF COLUMBIA, AND THE GOVERNOR OF WASHINGTON AS AMICI CURIAE IN SUPPORT OF RESPONDENTS ON SEVERABILITY

◆

KAMALA D. HARRIS
Attorney General
of California
TRAVIS LEBLANC
Special Assistant
Attorney General
MANUEL M. MEDEIROS
State Solicitor General

DANIEL J. POWELL
Deputy Attorney General
Counsel of Record
455 Golden Gate Avenue
San Francisco, CA 94102
(415) 703-5830
Daniel.Powell@doj.ca.gov
Counsel for Amici Curiae

[Additional Counsel Listed On Inside Cover]

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

GEORGE JEPSEN
Attorney General
of Connecticut
55 Elm Street
Hartford, Connecticut 06106

JOSEPH R. BIDEN, III
Attorney General of Delaware
820 N. French Street
Wilmington, Delaware 19801

DAVID M. LOUIE
Attorney General of Hawaii
425 Queen Street
Honolulu, Hawaii 96813

LISA MADIGAN
Attorney General of Illinois
100 West Randolph Street
Chicago, Illinois 60601

TOM MILLER
Attorney General of Iowa
1305 East Walnut Street
Des Moines, Iowa 50319

DOUGLAS F. GANSLER
Attorney General of Maryland
200 St. Paul Place, 20th Floor
Baltimore, Maryland 21202

GARY K. KING
Attorney General
of New Mexico
P. O. Drawer 1508
Santa Fe, New Mexico 87504

ERIC T. SCHNEIDERMAN
Attorney General
of New York
120 Broadway, 25th Floor
New York, New York 10271

JOHN R. KROGER
Attorney General of Oregon
1162 Court Street N.E.
Salem, Oregon 97301

WILLIAM H. SORRELL
Attorney General
of Vermont
109 State Street
Montpelier, Vermont 05609

IRVIN B. NATHAN
Attorney General for
the District of Columbia
441 4th Street, N.W.,
Suite 600 South
Washington, D.C. 20001

CHRISTINE O. GREGOIRE
Governor of Washington
810 Third Avenue, Suite 500
Seattle, Washington 98104

QUESTION PRESENTED

To what extent (if any) can the individual mandate provision of the Affordable Care Act be severed from the remainder of the Act?

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INTEREST OF AMICI STATES

Amici, the States of California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, New Mexico, New York, Oregon, and Vermont, the District of Columbia, and the Governor of Washington (collectively, "Amici States"), have a vital interest in protecting the health and welfare of their citizens, interests that are advanced by the Patient Protection and Affordable Care Act. This Act comprehensively reforms the American health care system. As the Amici States explained in their briefs supporting the United States on the constitutionality of the minimum coverage provision, the Amici States' interests are best served through application of the Affordable Care Act in its entirety, including the requirement that non-exempt adults maintain adequate health insurance coverage. Even if that provision is determined to be an unconstitutional exercise of Congress's Commerce Clause authority, the remainder of the Affordable Care Act is crucial to assisting States in ensuring that their citizens have access to affordable health care.

Since the Affordable Care Act was passed in 2010, the States have begun to implement substantial portions of the Act, such as prohibiting insurance companies from denying coverage to children with pre-existing conditions, allowing States to better regulate insurance rates, and helping States establish high risk pools for their citizens. Today, these reforms are bringing real relief to States, medical providers, and families across the country. The reforms are also helping all States grapple with the serious problem of the high number of uninsured citizens. While the minimum coverage provision unquestionably advances the Congressional goal of comprehensive health care reform in general and private health insurance reform in particular, the minimum coverage provision operates independently of the vast majority of the Affordable Care Act, which should remain in effect.

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INTRODUCTION AND SUMMARY OF ARGUMENT

The Affordable Care Act (ACA)[1] is a needed measure to assist States in grappling with the nation's health care crisis. The minimum coverage provision, which starting in 2014 will require non-exempt adults to maintain adequate health coverage, is but one provision of a 2700-page comprehensive health care reform law intended to increase Americans' access to affordable health care. As Respondents and Amici States argued in their briefing on the constitutionality of the minimum coverage provision, that provision is a justifiable exercise of Congress's Commerce Clause authority. If, however, this Court determines that the minimum coverage provision is unconstitutional, it should be severed from the ACA. While its invalidation would mean that fewer Americans would have access to affordable private health insurance than would otherwise be the case, the remainder of the ACA would still operate to ensure access to affordable health care for Americans across the country.[2]

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[1] ACA refers to the Patient Protection and Affordable Care Act, Pub. Law No. 111-148, 124 Stat. 119 (2010) and the Health care and Education Reconciliation Act of 2010, Pub. Law No. 111-152, 124 Stat. 1029.

In addressing the effect of an unconstitutional provision, the Court retains the portions that are constitutionally valid, capable of functioning independently, and consistent with Congress's goals in enacting the statute. *United States v. Booker*, 543 U.S. 220, 249, 258 (2005). In this case, the vast majority of the ACA is unquestionably constitutional and capable of functioning independently of the minimum coverage provision. Congress's goal when it enacted the ACA was to increase the availability and accessibility of affordable health care. Congress intended the other ways in which the ACA expands health insurance coverage – through Medicaid, the private market, and employer-sponsored plans – to remain intact. So too did Congress intend to preserve the myriad health care reforms that are unconnected to the minimum coverage provision. Indeed, many of those reforms are already in effect and had been previously considered by Congress in stand-alone bills.

Although this litigation has focused on the minimum coverage provision and related sections, the

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[2] Respondents have conceded that the guaranteed issue and community rating provisions that go into effect in 2014 should be invalidated if the Court concludes the minimum coverage provision is unconstitutional. Amici States do not seek to challenge this concession.

ACA represents a system-wide reform of health care throughout the United States. Broadly speaking, the ACA can be divided into six distinct categories: (1) increasing access to health insurance in the private market; (2) reforming the health insurance industry through the inclusion of consumer protections; (3) increasing access to and the quality of care offered by Medicaid; (4) improving the quality and efficiency of health care generally; (5) improving public health and preventing chronic disease; and (6) supporting the health care workforce. The ACA regulates subjects as diverse as diabetes care, breast cancer, elder abuse, and access to pharmaceuticals in clinical trials. 42 U.S.C. §§ 247b-9a; 280m; 1397j *et seq.*, ACA, Title VII, §§ 7001 *et seq.* It makes many reforms to Medicare and Medicaid to improve the quality of care given to beneficiaries, as well as to reduce costs to federal and state governments. ACA, Title II, §§ 2001 *et seq.* It encourages individuals to enter the nursing profession and doctors to practice in rural areas. ACA, §§ 5202 and 5208; 42 U.S.C. §§ 296p-1, 2970, 2963, 2391 *et seq.* These varied reforms are just a few of the changes to the provision of affordable health care in the United States that have nothing to do with the minimum coverage provision or even private insurance coverage generally.

Even within the category of expanding coverage, the minimum coverage provision is only one of several ways in which Congress ensured greater access to affordable health insurance. In addition to requiring non-exempt adults to maintain adequate health coverage, the ACA expands access to employer-sponsored health insurance by requiring large businesses to cover their employees and by providing incentives for small businesses to do so. 26 U.S.C. §§ 45R, 4980H. The ACA also increases the number of Americans with health insurance by expanding Medicaid eligibility to include individuals below 133 percent of the federal poverty line. 42 U.S.C. § 1396a. And many of the reforms to the private insurance market, such as requiring that health plans cover certain preventative services, 42 U.S.C. § 300gg-13, prohibiting rescission except in specified circumstances, 42 U.S.C. § 300gg-12, and various reporting requirements have nothing to do with the minimum coverage provision. Health insurance reforms like these are completely independent of the minimum coverage provision and can still operate as Congress intended, even in the absence of that provision. The Court should not, as Petitioners suggest, engage in a wholesale invalidation of this important and monumental health care reform effort.

Moreover, the underlying purpose of severability analysis – to give as much effect as possible to the acts of the people's elected representatives – is doubly implicated in this case. States throughout the nation have taken up Congress's request that States immediately begin to implement the ACA. Congress was well aware at the time it passed the ACA that the minimum coverage provision would be challenged in court: indeed, lawsuits were filed the same afternoon President Obama signed the ACA into law. The fact that Congress nevertheless encouraged States to pass legislation, apply for grants, and begin implementing the ACA even before the minimum coverage provision went into effect shows that Congress intended the minimum coverage provision to be severable. Similarly, Congress's direction that many provisions of the ACA should take effect prior to the minimum coverage provision demonstrates that these provisions can and should operate independently of the minimum coverage provision.

Finally, many States and individuals have made decisions and committed resources in reliance on the continued application of the ACA. Wholesale invalidation of the ACA would upend these decisions, waste unquantifiable resources, and wreak havoc on States, local governments, and private citizens across the country. States, for instance, have budgeted for anticipated grants, entered into contracts with private individuals, and overhauled their health care regulations, all in reliance on provisions that are completely independent of the minimum coverage provision. So too have individuals undoubtedly made important, life-altering decisions in reliance on the ACA's provisions, including how they will obtain and pay for health care. This upheaval would have disastrous independent costs that would be avoided by severing the minimum coverage provision as Congress intended.

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ARGUMENT

I. THE REMAINDER OF THE AFFORDABLE CARE ACT IS SEVERABLE FROM THE MINIMUM COVERAGE PROVISION

A. Courts Presume That An Unconstitutional Provision Is Severable If The Remainder Of The Act Can Function Independently And In Accordance With Congressional Intent

The minimum coverage provision is severable from the vast majority of the Patient Protection and Affordable Care Act (ACA). Petitioners' view that the 2700-page Affordable Care Act (ACA) should be struck down in its entirety if this Court determines that one provision is unconstitutional ignores the well-settled principle that courts "should refrain from invalidating more of the statute than necessary." *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984). Even in the absence of a severability provision in an act, this Court has stated that it prefers "to sever its problematic portions while leaving the remainder intact." *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 328-29 (2006).

The effort to salvage as much of a statute as possible arises from the presumption of the constitutionality of a statute and the fact that a "ruling of unconstitutionality frustrates the intent of the elected representatives of the people." *Regan*, 468 U.S. at 652. Accordingly, the burden is on the party arguing for total invalidation to show that, if faced with the unconstitutionality of one provision, Congress would have preferred no Act at all. *See, e.g., Free Enterprise Fund v. Public Company Accounting Oversight Board*, 130 S.Ct. 3138 (2010); *United States v. Booker*, 543 U.S. 220, 249 (2005). Consistent with this standard, the Court should "retain those portions of the Act that are (1) constitutionally valid, (2) capable of 'functioning independently,' and (3) consistent with Congress's basic objectives in enacting the statute." *Booker*, 543 U.S. at 258. Petitioners cannot meet their burden or this standard.

B. The Remainder Of The ACA Can Function Independently Of The Minimum Coverage Provision

In this case, the constitutionality of the vast majority of the ACA is unquestioned. Moreover, there is no reasonable dispute that the vast majority of the ACA is capable of operating independent of the minimum coverage provision. The minimum coverage provision is just one of several ways in which Congress intended to ensure that more Americans were given access to health care and that the quality of health care is improved. Many of Congress's goals bear little or no relation to the minimum coverage provision: reforming Medicaid; improving the quality of health care generally; improving public health and preventing chronic disease; and supporting the health care workforce. The minimum coverage provision is also independent of the majority of the reforms that increase access to health insurance in the private market. Requiring large businesses to offer health insurance to employees and encouraging small businesses to do so do not depend on the minimum coverage provision for their operation. Neither do many of the reforms to the health insurance industry depend upon the minimum coverage provision, such as restricting the practice of rescission, allowing beneficiaries to appeal adverse coverage decisions, or permitting States to review insurance rates.

Moreover, as is the case with many omnibus bills, the ACA contains parts that are in fact separate acts generally related to health care that were included in a comprehensive health care bill. Indeed, many of the provisions of ACA were originally introduced as entirely separate bills that did not even conceive of the minimum coverage provision and which could operate independently of it. Section 6701, for instance, is titled the Elder Justice Act of 2009, and incorporates many provisions of S. 795, also called the Elder Justice Act of 2009. The Elder Justice Act establishes an Elder Justice Coordinating Counsel to coordinate federal, state, and local efforts to combat the abuse of elder individuals, and provides grants to establish elder abuse, neglect, and exploitation forensic centers. The Elder Justice Act has nothing to do with the minimum coverage provision or private health insurance generally. Section 10407, known as the Catalyst to Better Diabetes Care Act of 2009, closely tracks many bills that were previously introduced in the 111th Congress, including S. 1473, 111th Cong. (2009) and H.R. 1402, 111th Cong. (2009). The ACA is replete with provisions that are referred to as independent acts, many of which were separately introduced, and all of which would have been effective if enacted separately.[3] Each of these is independent of, and severable from, the minimum coverage provision.

Petitioners' assertion that the entire ACA should fall with the minimum coverage provision (if it is declared invalid) rests upon the false premise that if Congress could not ensure that non-exempt adults maintain adequate health insurance coverage, it would rather that no additional individuals be covered and that none of the ACA's other general health care reforms take effect. *Cf. New York v. United States*, 505 U.S. 144, 186 (1992). Nothing in the text, structure, or legislative history of the ACA indicates that Congress intended that the invalidation of one way of expanding health care required invalidation of the rest, particularly since many of the ACA's provisions have nothing to do with the private health insurance market.

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[3] *See, e.g.*, § 7001, Biologics Price Compensation and Innovation Act of 2009; § 10409, Curses Acceleration Network Act of 2009; § 10410, Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009 or the ENHANCED Act of 2009; § 10411, Congenital Heart Failure Act; § 10413, Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009 or the EARLY Act.

II. THE MANNER IN WHICH THE AFFORDABLE CARE ACT HAS BEEN IMPLEMENTED SHOWS THAT THE MINIMUM COVERAGE PROVISION IS SEVERABLE

Examining the Affordable Care Act as a whole shows that Congress intended for its disparate parts to act separately even while they all worked toward a common goal: increasing access to affordable and reliable health care. Congress left a substantial role for the States in implementing the ACA, a role that many of the Amici States have already begun to fulfill. Congress would not have intended the States to expend significant effort in implementing provisions of the ACA that would be stricken if the minimum coverage provision were declared unconstitutional. The structure of the ACA also shows that its many provisions were intended to operate independently of the minimum coverage provision. While the minimum coverage provision does not go into effect until 2014, many provisions of the ACA are already in operation, showing that they are capable of functioning independently of the minimum coverage provision and that Congress intended for them to remain in effect.

A. Ongoing State Implementation Of The Affordable Care Act Supports Severance Of The Minimum Coverage Provision

Since its passage, the States have actively implemented many provisions of the ACA, further illustrating that its provisions are severable from the minimum coverage provision. As demonstrated in the

Amici States' brief on the constitutionality of the minimum coverage provision, the ACA embodies cooperative federalism, a manner of legislating in which Congress "allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory program, structured to meet their own particular needs." Brief of the States of Maryland, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, New Mexico, New York, Oregon, and Vermont, the District of Columbia, and the Virgin Islands As Amici Curiae in Support of Petitioners (Addressing Minimum Coverage Provision) at p. 29-30 (quoting *Hodel v. Virginia Surface Min. and Reclamation Ass'n, Inc.*, 452 U.S. 264, 289 (1981)). By authorizing States to establish Health Insurance Exchanges, enforce reforms governing insurance providers, and implement various other programs authorized under the ACA, Congress indicated its intent that these programs survive any constitutional challenge to the minimum coverage provision. Congress would not have encouraged States to spend massive amounts of resources, both financial and human, in implementing provisions that it intended to be invalidated should the minimum coverage provision be stricken.

The fact that many States – including both Amici and Petitioner States – have passed legislation implementing the ACA distinguishes this case from many of this Court's past severability cases and provides an even stronger reason why the Court should salvage as much of the ACA as possible. The animating principle behind the Court's severability analysis is based on separation of powers and the judiciary's desire to interfere as little as possible with the actions of the people's elected representatives. *See Regan*, 468 U.S. at 652. Invalidating any action of Congress is a drastic step, and one that is only taken when the unconstitutionality of a provision is clear. *See, e.g., Clinton v. City of New York*, 524 U.S. 417, 447 n. 42 (1998) ("When this Court is asked to invalidate a statutory provision that has been approved by both Houses of the Congress and signed by the President, particularly an Act of Congress that confronts a deeply vexing national problem, it should only do so for the most compelling constitutional reasons.") Severability analysis, which seeks to preserve as much of a Congressional act as possible, is an extension of the respect this Court pays to a coordinate branch of government, particularly that which is politically accountable. *See* John C. Nagle, *Severability*, 72 N.C. L. Rev. 203, 250 (1993).

In this case, the wholesale invalidation of the ACA would not simply frustrate an act of Congress, but also the many legislative acts of the democratically-elected officials of the States that have implemented the ACA. Since the Court strives to preserve legislative action wherever possible, there should be an even stronger presumption of severability where the acts of multiple legislatures are at issue. Similarly, principles of federalism, and the respect which the legislative acts of sovereign States are due, also counsel against wholesale invalidation of the ACA and the resulting nullification of many State statutes.

The many statutes enacted by the States pursuant to Congressional authorization and encouragement thus support the Eleventh Circuit's decision that the minimum coverage provision should be severed. Such active State involvement at this stage suggests Congress intended for the provisions implemented by the States to remain in force. It also illustrates that they are capable of functioning independent of the minimum coverage provision. The following are just some examples in which States have been implementing the Affordable Care Act.

1. The ACA Encourages States To Establish Health Benefit Exchanges

Congress gave States wide latitude to establish and operate Health Benefit Exchanges, which can operate independently of the minimum coverage provision under State oversight. 42 U.S.C. §§ 18031 *et seq*. The Exchanges are intended to allow individuals and small businesses to pool resources in order to purchase health insurance on more favorable terms. By bringing these entities together to form a large risk pool, the Exchanges will allow them to enjoy premiums and discounts similar to those routinely given to larger employers. The ACA permits (but does not require) States to establish their own Exchanges,[4] which many States have already begun to do. Oregon, for instance, passed a bill in June 2011 that established the Oregon Health Insurance Exchange Corporation, charged with administering that State's exchange. Senate Bill 99 (2011). Pursuant to that legislation, Governor Kitzhaber nominated, and the Oregon Senate confirmed, the nine members of the Exchange Corporation's Board.[5] The Board has already presented a preliminary business plan to Oregon lawmakers in late December 2011; a final version is due February 1, 2012.[6]

California officials have also been busy establishing that State's exchange. The California Health Benefit Exchange was created by two pieces of legislation: Assembly Bill 1602 (Ch. 655, Stats. 2010) and Senate Bill 900 (Ch. 659, Stats. 2010). California's exchange is comprised of five voting members, two appointed by the Governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly; the Secretary of the California Health and Human Services or his designee serves as the fifth voting member. These members have been conducting regular Board meetings since April 2011 and have hired an executive staff including the Exchange's Executive Director, Chief Operations Officer, and General Counsel. It has already awarded key contracts for its business and operations, and is soliciting contracts for the design of the federally-mandated web-based eligibility portal. Many States have followed the lead of Oregon and California; 49 States plus the District of Columbia have been awarded Exchange Planning Grants and 13 States plus the District of Columbia have been awarded Exchange Establishment Grants.[7]

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[4] If a State declines to establish a health care exchange, the federal government will operate one in that State. 42 U.S.C. § 18041(c).

[5] http://governor.oregon.gov/Gov/media_room/press_releases/p2011/press_092211.shtml.

[6] Associated Press, *Health Insurance Exchange Submits Details to Salem* (Dec. 27, 2011). The draft business plan is available online at https://orhix.org/uploads/orhix_business_plan.pdf.

2. States Have Begun Expanding Access To Medicaid And Implementing Other Changes To Medicaid Permitted By The ACA

States have already begun implementing the ACA's expansion of Medicaid to cover individuals whose income is at or below 133 percent of the federal poverty line (FPL). California, for instance, was one of the first States to request a waiver from the federal government so that it could begin covering those individuals prior to 2014 through its Bridge to Reform Waiver granted pursuant to 42 U.S.C. § 1315. California's Bridge to Reform is a demonstration program that allows California to provide health care coverage through county-based Low Income Health Programs to adults ages 19 to 64, with incomes at or below 133 percent of FPL who do not otherwise qualify for Medi-Cal under the usual rules. The demonstration also provides for alternative and enhanced funding for hospital care and public health initiatives. As of October 2011, 221,058 Californians were covered through the Low Income Health Programs, with an expected enrollment of 512,000 when the program is fully operational in 2012.

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[7] http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html.

Many States have begun implementing provisions in the ACA that aim to streamline care both to reduce costs and to make it easier for individuals to get the care they need. Section 2602 of the ACA, for instance, established the Federal Coordinated Health Care Office (FCHCO), which is charged with helping States develop programs to integrate service delivery and financing of care for persons who are dually eligible for Medicare and Medicaid. New York, along with California, Connecticut, and Oregon, has received a grant to develop models to integrate service for dually eligible individuals.[8] This program is especially important for New York. While dually eligible individuals account for a small portion of New York's total Medicaid enrollees – about 700,000 out of 5 million – they represent 45 percent of total Medicaid spending and an estimated 41 percent of

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[8] http://www.hhs.gov/news/press/2011pres/04/20110414a.html.

Medicare spending in New York. The establishment of the FCHCO is thus already helping States reduce their Medicaid and Medicare costs.

Oregon officials are currently in the process of implementing a program under section 2703 of the ACA, which is designed to help Medicaid beneficiaries coordinate their care. Many Medicaid recipients suffer from multiple or severe chronic conditions and would benefit from better coordination and management of the health and long-term services they receive. Such coordination avoids overlapping or conflicting care, makes it easier for individuals to obtain care, and leads to better health outcomes. Section 2703 of the ACA authorizes the Centers for Medicare and Medicaid Studies (CMS) to provide States such as Oregon with federal funding to support the development of these coordinated services.

Similarly, the ACA authorizes States to use Accountable Care Organizations (ACOs) to help coordinate care among doctors, hospitals, and other health care providers. In June 2011, the Oregon Legislature passed House Bill 3650, which established the Oregon Integrated and Coordinated Health Care Delivery System and authorized ACOs in that State. The Oregon Health Policy Board has already developed a draft implementation proposal, which will be finalized and sent to the Oregon Legislature in February

2012.[9] Illinois has also adopted an ACO model of care. Under House Bill 5420, signed into law by Governor Quinn on January 25, 2011, 50 percent of all individuals who are eligible for comprehensive medical benefits administered by Illinois must receive those benefits from an ACO. 215 Ill. Comp. Stat. 106/23. By helping providers coordinate care, States can help improve health, improve the quality of care, and lower costs. While complementing Congress's intent to increase the number of insured individuals through the minimum coverage provision, these goals are independently worthwhile and have been adopted by the States at Congress's expressed invitation, even though the minimum coverage provision has not yet gone into effect.

3. States Have Made Changes To Their Laws To Incorporate Reforms To The Health Insurance Market

States have also used their authority under the ACA to strengthen their review of the rates charged by insurance companies. Oregon, for instance, has received federal funding to contract with a consumer-advocacy group to help represent consumers. The ACA also made available funds that allowed Oregon to add staff members to provide a more in-depth and timely review of rate changes. The California

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[9] http://health.oregon.gov/OHA/OHPB/meetings/2012/2012-0110-cco.pdf.

Department of Insurance similarly has used the authority granted by the ACA to benefit consumers in that State. In 2010, the California Legislature enacted Senate Bill 1163 (Ch. 661, Stats. 2010), which subjects any rate increases filed after January 1, 2011 to review by the Department of Insurance or the Department of Managed Health Care. Because of the additional authority granted to state officials under the ACA, Blue Shield of California was forced to rescind proposed rate increases that would have increased some rates by as much as 87 percent.[10]

States have also enacted legislation incorporating into state law many of the consumer protections in the ACA. On July 20, 2011, New York Governor Andrew Cuomo signed Chapter 29, Laws of New York (2011), which brings various provisions of New York's Insurance Law and Public Health Law into compliance with the ACA's reforms. Among other things, Chapter 29 requires insurance policies to cover children until the age of 26 (§§ 2, 24, 31, 35); bans lifetime limitations on coverage (§§ 10, 12, 42); bars insurers from excluding children from coverage based on pre-existing conditions (§§ 23, 43, 50); and provides for expedited external appeals (§§ 54, 57, 64, 67). Many other States have followed suit.

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[10] R. Abelson, *Insurer to Forego Rate Rise*, N.Y. TIMES B1 (Mar. 17, 2011).

4. California's Experience Illustrates How Many Provisions Of The ACA States Have Begun To Carry Out

Although each of the Amici States has devoted a significant amount of time, energy, and resources in implementing the ACA to benefit their citizens, a more detailed examination of one State illustrates the extent to which States have implemented the ACA consistent with Congressional intent. As the State with the largest uninsured population in the country, California has been aggressive in putting the ACA into operation. California has passed at least eleven separate pieces of legislation implementing provisions of the ACA:

- Senate Bill 51 (Ch. 644, Stats. 2011) (requires that health plans and insurers meet federal annual and lifetime benefit limits and to issue rebates to consumers when health plans or insurers fail to meet specified medical loss ratios)
- Assembly Bill 2470 (Ch. 658, Stats. 2010) (prohibits health plans and insurers from rescinding or canceling coverage, except under specified circumstances)
- Assembly Bill 2345 (Ch. 657, Stats. 2010) (requires that health plans and insurers cover certain preventative services)
- Senate Bill 1088 (requires, with specified exemptions, that health plans and insurers offer coverage for dependent children under the age of 26)

- Assembly Bill 2244 (prohibits health plans and insurance companies from imposing pre-existing condition exclusions on coverage for children under the age of 19)
- Assembly Bill 922 (transfers Office of the Patient Advocate from Department of Managed Health Care to California Health and Human Services and makes other changes to conform with 42 U.S.C. § 300gg-93, concerning health insurance consumer assistance offices)
- Assembly Bill 1163 (Ch. 661, Stats. 2010) (subjects rate increases filed after January 1, 2011 to review by the Department of Managed Health Care or the Department of Insurance)
- Assembly Bill 1887 and Senate Bill 227 (Ch. 31, Stats. 2010 (implements California's Pre-Existing Condition Insurance Plan)
- Senate Bill 900 (Ch. 659, Stats. 2010) and Assembly Bill 1602 (Ch. 655, Stats. 2010) (establishes California's Health Benefits Exchange)

In addition to the time and effort spent by the California Legislature in enacting these provisions, each statute mandates action by state officials, including the Department of Managed Health Care, Department of Insurance, and Department of Health Care Services, to mention just a few. Pursuant to the ACA and California legislation, officials have established an entirely new agency (the California

Health Benefits Exchange), negotiated a wide-ranging Medicaid waiver and implemented an expansion of Medicaid, begun planning a massive expansion of California's public health infrastructure, and established the California Pre-Existing Condition Insurance Plan (PCIP).

California is just one example among the many States that have already begun to implement the ACA. As discussed, many Amici States have enacted legislation establishing health benefit exchanges, incorporating protections for consumers into state law, granting their insurance officials authority to review insurance rate increases, and taking advantage of provisions in the ACA that allow for state innovation in Medicaid. Collectively, the Amici States have spent a tremendous amount of resources implementing portions of the ACA that are unquestionably constitutional. The States undertook these efforts in good faith: were they to wait until the challenges to the minimum coverage provision were resolved, there would be insufficient time to prepare for the full implementation of the ACA, and the citizens of the Amici States would have been denied the full protections of the ACA in the interim.

The fact that Congress designed the ACA to allow States to implement many of its provisions shows that these provisions can, and were intended to, operate independently of the minimum coverage provision. Congress was well aware when it passed the ACA that a constitutional challenge to the minimum coverage provision was likely. Congress surely would not have encouraged state legislatures and state public health officials to spend considerable time, money, and energy implementing diverse provisions such as Medicaid reform, establishment of health exchanges, and consumer protection provisions if it thought that those provisions would be invalidated along with the minimum coverage provision or if it thought that those provisions could operate only in coordination with the minimum coverage provision. Rather, the significant involvement of state officials, as specifically contemplated and encouraged by the ACA, shows that Congress intended for those provisions to survive even if a challenge to the minimum coverage provision were successful.

B. The Many Provisions Of The ACA That Are Already Effective Indicate Congress Intended Them To Operate Independently Of The Minimum Coverage Provision

While the minimum coverage provision does not go into effect until 2014, Congress directed that many important reforms take effect well before then. Congress thus envisioned that these reforms were independent of, and should survive a constitutional challenge to, the minimum coverage provision. Individuals in the Amici States are already benefitting from these important provisions, which have expanded the availability of insurance while making it more affordable. Congress was well aware of the potential for constitutional challenge to the minimum coverage provision, and its decision to make provisions effective well before 2014 indicates it intended them to survive any such challenge.

Specifically, the ACA provides immediate benefits for children and young adults that should survive any challenge to the minimum coverage provision. Effective September 23, 2010, children cannot be denied insurance coverage based on a pre-existing condition. ACA § 1255; 42 U.S.C. § 200gg-1. Also effective on that date is a requirement that insurance companies permit parents to insure their children until the age of 26. 42 U.S.C. § 300gg-14.

Senior citizens also received immediate benefits under the ACA. For instance, the ACA has already begun to close the so-called "donut hole" in prescription drug coverage that costs seniors millions of dollars each year. The donut hole refers to a gap in coverage between what is covered by Part D (Medicare prescription drug coverage) and what is covered by catastrophic coverage. In 2012, this gap in coverage required seniors to pay up to $4700 each for their prescription medications.[11] The ACA gradually eliminates this gap in coverage in two ways such that by 2020, Medicare recipients will have to pay only 25 percent of the cost of prescription drugs in the donut hole. 42 U.S.C. § 1395w-114a. For 2012, Medicaid beneficiaries will only pay 50 percent of the cost of brand-name drugs, and 86% of the cost of generic drugs within the donut hole.[12] In addition to these prescription drug benefits, the ACA provides for free preventive care for seniors, as well as reinsurance for early retirees, 42 U.S.C. § 18002. These provisions protecting seniors are in effect now, they have no relation to the minimum cov-erage provision, and there is no indication Congress intended for those benefits to expire if the minimum coverage provision were invalidated.

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[11] CMS Office of Public Affairs, Final 2012 Payment Policies For Medicare Drug And Health Plans Would Maintain Beneficiary Choice, Improve Quality, And Lower Part D Cost-Sharing (April 4, 2011).

Congress also enacted provisions ending certain abusive insurance practices that have already gone into effect, all of which operate independently of the minimum coverage provision. One important reform is the ban on rescission, a common practice in which insurance companies rescinded coverage, often on the pretext of a technicality, when an individual suffered a catastrophic illness that the insurance company would be otherwise required to cover. Since it became effective on September 23, 2010, section 2712 of the ACA (codified at 42 U.S.C. § 300gg-12) prohibits insurance companies from rescinding coverage except in cases of fraud or intentional misrepresentation of a material fact. In addition, the ACA slows the rise in premiums by requiring that 85 percent of premiums in the large group market be used for health care and quality improvement. 42 U.S.C. § 300gg-18(b)(1). And as of September 23, 2010, insurance companies may not impose a lifetime limit on benefits. 42 U.S.C. § 300gg-11(a)(1)(A). Finally, the ACA guarantees beneficiaries the right to appeal the adverse coverage determinations of insurance providers. 42 U.S.C. § 300gg-19.

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[12] Centers for Medicare and Medicaid Studies, Closing the Coverage Gap – Medicare Prescription Drugs Are Becoming More Affordable (Nov. 2012).

As each of these provisions is currently in effect, Petitioners cannot claim that their proper functioning is dependent upon ensuring that individuals maintain insurance coverage. The fact that Congress directed they become effective prior to the effective date of the minimum coverage provision reflects Congress's determination that they can and should operate freestanding. Each of them, and the myriad other provisions of the ACA already in force, should be severed from the minimum coverage provision if this Court concludes it is unconstitutional.

III. STATES AND INDIVIDUALS HAVE RELIED ON THE REFORMS IN THE AFFORDABLE CARE ACT

Both States and individuals have made decisions and committed resources in reliance on the implementation of the ACA. Wholesale invalidation would mean these resources are lost and decisions are upended. This upheaval will itself incur additional fiscal and human costs for States and individuals. Petitioners have failed to meet their burden of showing that the majority of the ACA cannot function independently of the minimum coverage provision or in a manner that is inconsistent with Congressional intent. The fact that States have relied on the ACA in changing their laws and in applying for and being awarded grants is another reason this Court should preserve the vast majority of the ACA in the event the minimum coverage provision is invalidated.

Like those of many States, officials in California have relied on numerous grants made pursuant to the ACA. As discussed above, California has obtained a waiver to begin offering Medicaid to individuals whose incomes are under 133 percent of the FPL; ACA grants that have already been awarded to the State make the agreement between California and the federal government possible. If the ACA is stricken down in its entirety, it is unclear whether the federal government will still be required to provide the funds anticipated by the Medicaid waiver or whether California will be released from its obligations. Hundreds of thousands of individuals could thus face losing their health insurance.

Independent of its Medicaid expansion, California has been awarded $232.8 million in grant funding under the ACA.[13] These grant funds are being used for a variety of activities, from upgrading state and local hospital infrastructure, to training California's primary care workforce, to establishing new community health centers in underserved areas. California officials have begun to use those grants for their intended purposes, and should the ACA be invalidated, they could be rescinded.

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[13] http://www.healthcare.gov/law/resources/ca.html.

Moreover, in reliance on those grants and the requirements of the ACA, California and other states have started entering into contracts with third parties, all of which may be void if the ACA is struck down in its entirety. California has already begun solicitation of a multi-million dollar contract to implement California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). Section 1413 of the ACA (codified at 42 U.S.C. § 18083) requires that States operating an exchange establish a single website whereby individuals can apply for any State health programs, including Medicaid, the Children's Health Insurance Program, or insurance through the Exchange. The scope of California's 160-page solicitation, which was issued by the California Health Benefits Exchange, the Department of Health Care Services, and the Managed Risk Medical Insurance Board, illustrates how much effort States have taken in implementing the ACA. California's solicitation is but one of many instances where States are entering into agreements with third parties.[14] Should this Court invalidate the entire ACA, millions of dollars would be wasted and litigation over the validity of contracts such as this would invariably ensue.

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[14] http://www.healthexchange.ca.gov/Documents/Solicitation%20HBEX4%20-%20CalHEERS%20Dev%20and%20Ops%20Services.pdf.

Many consumers are benefitting from the ACA's reforms. Hundreds of thousands of individuals could immediately lose their health insurance if this Court invalidates the ACA in its entirety. Children and young adults under the age of 26 who are covered under their parents' insurance could be dropped from their carrier. Newly-eligible Medicaid recipients, or members of the high risk insurance pools could see their insurance coverage disappear. Individuals who would have otherwise reached the lifetime cap on benefits would once again be effectively forced to pay for all their medical coverage out-of-pocket. Seniors will pay more for their prescription medications, and insurance companies will be free to raise their rates without the fear of additional state oversight.

Undoubtedly, many of the individuals who have benefitted from the ACA are relying on these reforms to obtain needed medical care. For instance, a young adult might have decided to take a position with a small business that did not offer health care, secure in the knowledge that she could remain covered under her parents' insurance policy until she was 26. If the ACA were invalidated in its entirety, she, among countless individuals, could stand to lose health insurance on which they now rely. An individual in the middle of his cancer treatment could be forced to halt his care if lifetime limits were reinstated and individuals in high-risk groups could once again find themselves without health insurance, subjecting them to increased illness and financial hardship.

Hospitals are also beginning to make decisions based on the ACA that would be called into question should it be invalidated in its entirety. For instance, hospitals around the country are being encouraged to create additional residency training programs in primary care. ACA § 5503. The hospitals that have done so are relying on millions of dollars of grant funding provided by the ACA over the next four years to pay for these positions. If the ACA were invalidated in its entirety, the hospitals could lose that funding and would be faced with either eliminating these additional positions or paying for them with scarce hospital resources. Moreover, hospitals are beginning to plan and implement changes in the way health care is provided. For instance, under the Hospital Value-Based Purchasing Program, Medicaid will pay hospitals not just on the quantity of acute inpatient care, but also on its quality. 42 U.S.C. § 1395ww(o). There are many changes to how Medicaid and Medicare will pay providers, all of whom are adjusting to the new rules under the ACA.

So too are medical professionals changing their practices as a result of the ACA. As an example, the ACA seeks to encourage doctors and nurses to practice in rural areas through scholarships and loan repayment programs and training grants. 42 U.S.C. § 293m. For a doctor who decided to move to a rural area and practice medicine based on the promise that the government would help pay back his loans and make it more affordable to practice in a rural area, invalidation of the ACA could mean that the doctor would be faced with more expenses than anticipated. Or he might choose to leave, affecting the hospital that hired him and the patients that had been seeing him.

Small businesses may also suffer if the ACA is struck down in its entirety. Many small businesses are already relying on the ACA's tax credits, which make it financially feasible for smaller businesses to offer health insurance. 26 U.S.C. § 45R. If this provision of the ACA is invalidated with the minimum coverage provision, the companies that had offered their employees health coverage would be forced to decide between paying the extra money it costs to insure their employees, which might be cost prohibitive, passing along those costs to their employees, or dropping health coverage altogether.

In sum, many States, third parties, businesses, and individuals will be adversely affected if the entire ACA is invalidated, a result that is inconsistent with Congress's intent and is not required by any of this Court's precedents. The toll on individuals who will lose their insurance because of the ACA's invalidation cannot be overstated. The health consequences are obvious: diseases that could have been prevented with routine medical care will go unchecked. People will be forced to forego needed medical care for chronic illnesses. Many individuals will be denied lifesaving treatments. The financial toll is equally clear: many individuals will lose their jobs because they are sick, or be forced into bankruptcy because they are unable to pay their medical bills. Hundreds of thousands of individuals are already relying on the health care reform instituted in the ACA, well before the minimum coverage provision has gone into effect. While the invalidation of the minimum coverage provision would cause much hardship, this Court can forestall further damage by severing the minimum coverage provision from the remainder of the Act as Congress intended.

◆

CONCLUSION

The minimum coverage provision is constitutional. If, however, the Court invalidates the minimum coverage provision, the Court should sever it from the remainder of the ACA.

Dated: January 27, 2012

Respectfully submitted,

KAMALA D. HARRIS
Attorney General
of California
TRAVIS LEBLANC
Special Assistant
Attorney General
MANUEL M. MEDEIROS
State Solicitor General
DANIEL J. POWELL*
Deputy Attorney General

**Counsel of Record*
Counsel for Amici Curiae

AMICUS
CURIAE
BRIEF

No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, ET AL.,
Petitioners,

v.

UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Eleventh Circuit

BRIEF OF CATHOLIC SISTERS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS (MEDICAID EXPANSION)

David J. Burman
Counsel of Record
PERKINS COIE LLP
1201 Third Avenue
Suite 4800
Seattle, WA 98101-3099
(206) 359-8426
DBurman@perkinscoie.com

Counsel for Amici Curiae

Joren S. Bass
Kenneth J. Halpern
Euphemia N. Thomopulos
Alan Murphy
Anahit Samarjian
PERKINS COIE LLP
4 Embarcadero Center
Suite 2400
San Francisco, CA 94111-4131
(415) 344-7000

February 17, 2012

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTION PRESENTED

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, provides that, beginning in 2014, eligibility for Medicaid shall extend to certain individuals with income up to 133% of the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2012).

The question presented is whether the extension of Medicaid eligibility is a valid exercise of Congress's power to set the terms on which it will appropriate federal funds.

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INTERESTS OF *AMICI CURIAE*[1]

Amici curiae represent the leadership of Catholic women's religious orders from across the United States. *Amici* and the orders they serve have a long history of public service in healthcare in America dating back to the 1700s. These services include founding hospitals and free clinics and providing free healthcare to the underprivileged and uninsured. The work by *Amici* gives them a unique perspective on the unmet healthcare needs of the poor, as well as on the positive impact that will result from the Patient Protection and Affordable Care Act ("ACA" or the "Act"). A complete list of *Amici* can be found in the Appendix.

Amici have witnessed firsthand the national crisis that prompted Congress to pass the ACA. In particular, *Amici* have seen the devastating impact of the lack of affordable health insurance and healthcare on women, children, and other vulnerable members of society.

Amici believe that a civilized society must ensure the provision of basic healthcare to its citizens regardless of their ability to pay for it. They further believe it is a moral imperative that all levels of government institute programs that ensure the poor receive such care. They believe Medicaid expansion under the Act is critical to the communities they serve. *Amici* and other Catholic Sisters therefore advocated for passage of the Act. In a letter to Congress sent shortly before the Act was passed, the Sisters wrote:

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *Amici* represent that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *Amici* or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of amicus briefs and have filed letters reflecting their blanket consent with the Clerk.

> We have witnessed firsthand the impact of our national healthcare crisis, particularly its impact on women, children and people who are poor. We see the toll on families who have delayed seeking care due to a lack of health insurance coverage or lack of funds with which to pay high deductibles and co-pays. We have counseled and prayed with men, women, and children who have been denied health care coverage by insurance companies. We have witnessed early and avoidable deaths because of delayed medical treatment.
>
> The health care bill . . . will expand coverage to over 30 million uninsured Americans. While it is an imperfect measure, it is a crucial next step in realizing health care for all. It will invest in preventative care. It will bar insurers from denying coverage based on pre-existing conditions. It will make crucial investments in community health centers that largely serve poor women and children.[2]

The Sisters believe that the ACA provides crucial support for those most in need of assistance. In particular, by the year 2014 the Medicaid expansion will provide healthcare to an estimated 9 million Americans of the 50 million who are currently uninsured. In the next decade, the protections provided by the Medicaid expansion will grow to cover more than 17 million Americans.

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[2] *See* http://www.networklobby.org/legislation/catholic-sisters-letter-support-healthcare-reform-bill.

Amici submit this brief to explain the critical importance of the expanded Medicaid program to the welfare of the United States, as well as to demonstrate why every state should welcome the expanded Medicaid provisions.

SUMMARY OF ARGUMENT

As part of the ACA, Congress expanded Medicaid to respond to a dire and growing problem faced by millions of Americans who are unable to obtain health insurance or pay for quality healthcare. *Amici*, whose work includes serving those without access to affordable healthcare, submit this brief to explain how the Medicaid expansion helps to resolve this problem and therefore serves the general welfare of the United States. *Amici*'s work with the uninsured compels their conclusion that the Medicaid expansion will greatly improve the lives of millions of Americans—and their relatives and communities—by providing them with access to quality healthcare.

Amici also submit this brief to refute Petitioners' argument that they are being coerced to accept the expanded Medicaid. In truth, Petitioners receive the significant benefit of expanded health coverage for their most vulnerable citizens largely paid for by the federal government. This is why *Amici*, who provide care for the poor, advocated for the ACA's passage. Likewise, decisions of this Court and the circuit courts have repeatedly held that similar laws, including similar expansions of Medicaid itself, are non-coercive. Indeed, given the discretion afforded the states under the Act, the states have great flexibility to address local concerns.

ARGUMENT

I. THE ACA'S MEDICAID EXPANSION HELPS ADDRESS A NATIONAL PROBLEM OF CRITICAL IMPORTANCE AND SERVES THE COUNTRY'S GENERAL WELFARE

A. The ACA's Medicaid Expansion Helps to Resolve a Crisis that Threatens the National Economy

The crisis resulting from the high number of uninsured Americans is dire. Approximately 50 million individuals in America are uninsured, with significant costs to our national economy. *See Florida v. United States Dep't of Health & Human Servs.*, 648 F.3d 1235, 1244 & n.7 (11th Cir. 2011). As the congressional findings supporting the Act recognize, the uncompensated expense of providing healthcare to uninsured individuals costs as much as $43 billion annually, much of which is passed on to the insured in the form of higher insurance premiums. *See* ACA, 42 U.S.C. § 18091(a)(2)(F). Underwriting costs add as much as $90 billion annually. *Id.* § 18091(a)(2)(J). As a result of the poorer health and shorter life spans of the uninsured, the economy loses up to $207 billion a year. *Id.* § 18091(a)(2)(E). *Amici* find that much of their efforts to provide care to the uninsured address care sought only when the need becomes a crisis, which results in the need for more complex care, worse clinical outcomes, and expenditure of scarce healthcare funds that should have been unnecessary.

The Constitution grants Congress the right to "lay and collect Taxes . . . to . . . provide for the . . . general Welfare of the United States." U.S. Const. art. 1, § 8, cl. 1. *Amici* submit this brief to explain that the Medicaid expansion helps to resolve the crisis in health insurance and healthcare, thereby serving the general welfare of the United States.

Amici, some of whom run "safety net" hospitals or other facilities or programs that serve a significant portion of the uninsured, bear a disproportionate portion of the costs by the high number of uninsured. For example, the Sisters of Mercy of the Americas sponsor or co-sponsor six health systems and many health-related facilities throughout the United States, including hospitals, long-term care facilities, rehabilitation centers, and family care and outreach centers. The Franciscan Sisters of Mary provide free or discounted care to the uninsured and minimally-insured in their community, and in 2010 they absorbed $31 million in unpaid Medicaid costs. For facilities like those run by *Amici*, uncompensated care can amount to more than 20% of total costs, compared to the average 5.5% of total costs for all hospitals. *See* Changes in Health Care Financing & Org., *Challenges Facing the Health Care Safety Net* (Feb. 2008).[3]

As *Amici* see in their daily work with the uninsured, the economic effects on average American families are severe. As Congress recognized, more than 60% of all personal bankruptcies are caused in part by medical expenses. 42 U.S.C. § 18091(a)(2)(G).

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[3] *Available at* http://www.hcfo.org/publications/challenges-facing-health-care-safety-net (citing "How Are Safety Net Hospitals Financed? Who Pays for 'Free Care?'" Nat. Ass'n of Public Hosps. & Health Sys. (Sept. 2004)).

As part of its overall solution, Congress expanded Medicaid eligibility. Specifically, the federal government will help participating states to provide coverage for most adults under age 65 with incomes up to 133% of the federal poverty level ("FPL"), or about $29,000 for a family of four. *Id.* § 1396a(a)(10)(A)(i)(VIII). Participating states will also provide Medicaid to all children whose families earn up to 133% of the FPL. *Id.* §§ 1396a(a)(10)(A)(i)(VII), 1396a(*l*)(1)(D), 1396a(*l*)(2)(C). And such states may not decrease existing Medicaid eligibility levels for adults and children that were in place as of March 23, 2010, until a state's Exchange is fully operational. *Id.* § 1396a(gg)(1). Children under age 26 who were receiving Medicaid but "aged out" of foster care will be newly eligible to continue receiving Medicaid. Pub. L. No. 111-148 § 2004, 124 Stat. 119 (to be codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(IX) effective Jan. 1, 2014).

To support the expanded Medicaid coverage, the federal government agreed to greatly expand its participation in providing Medicaid subsidies. In 2013 and 2014, primary care physicians will be paid at 100% of the Medicare payment rate. *Id.* § 1396a(a)(13)(C). States will receive 100% federal funding for the cost of the increasing payment rates for 2013 and 2014. *Id.* § 1396d(dd).

As a result of the Act's Medicaid expansion, an estimated 9 million of the 50 million uninsured will be covered by 2014 (increasing to 16 million by 2016 and

17 million by 2021). *See Florida*, 648 F.3d at 1246 & n.15.[4]

B. The Courts Have Afforded Congress Broad Latitude to Spend Funds in Support of the General Welfare

Congress has "wide latitude" to place conditions on federal funds to advance its policy objectives. *United States v. American Library Ass'n*, 539 U.S. 194, 203 (2003). Congressional spending must be intended to serve the general welfare and, perhaps, not add "conditions . . . unrelated 'to the federal interest in particular national projects or programs.'" *South Dakota v. Dole*, 483 U.S. 203, 207 (1987) (citation omitted); U.S. Const. art. 1, § 8, cl. 1. The ACA's Medicaid expansion serves the general welfare, and the federal interests served are at least as critical as the interests served in previous decisions where courts rejected coercion challenges to Medicaid revisions.

In *West Virginia v. U.S. Dep't. of Health & Human Servs.*, 289 F.3d 281 (4th Cir. 2002), the Fourth Circuit rejected a challenge to the constitutionality of Medicaid amendments requiring states to recover certain Medicaid expenditures from the estates of deceased beneficiaries. In 1993, Congress amended the Medicaid Act to compel states to either implement such "estate recovery" provisions or lose all or part of their federal Medicaid funds. *Id.* at 284. Recovered funds were to be split between the federal government and a state in proportion to the share of the state program's Medicaid expenditures each funded. *Id.* at 285. The Fourth Circuit ruled that Congress's action did not constitute impermissible coercion. *Id.* at 292.

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[4] *Citing CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, Before the Subcomm. on Health of the H. Comm. on Energy & Commerce 112th Cong. 18 tbl.3 (2011) (Statement of Douglas Elmendorf, Director, Cong. Budget Office), *available at* http://www.cbo.gov/ftpdocs/121xx/doc12119/03–30–HealthCareLegislation.pdf.

In *West Virginia*, Congress imposed the mandatory estate recovery condition in response to "rapidly escalating medical-care costs." *Id.* at 284. Congress anticipated its amendment would save the federal government $300 million over five years. *Id.* at 285. In enacting the legislation, therefore, Congress sought to advance the important, albeit routine, interest of restraining federal expenditures to save money. Congress's "pursuit of the general welfare" in that instance was less closely related to the legislation it enacted than the ACA is to the effort to extend health care benefits to millions of low-income Americans. As discussed above, there is a close connection between the ACA and the national project of reforming the health care system to better serve all Americans, including the neediest among us.

In *Oklahoma v. Schweiker*, 655 F.2d 401 (D.C. Cir. 1981), the D.C. Circuit upheld two sets of provisions that conditioned a state's receipt of Medicaid funds on how the state provided grants to the elderly, blind, and disabled. The Social Security Act established programs through which the federal government reimbursed the states for a portion of cash payments a state made to assist the needy in acquiring food, shelter, and medical care. *Id.* at 403 (referencing Titles I, X, and XIV of the Social Security Act). In 1972, Congress established the Supplemental Security Income (SSI) program to federalize these cash assistance programs by, among other changes, setting a uniform level of benefits for all recipients. *Id.* at 404 (discussing amended Title XVI of the Social Security Act); *see also* 42 U.S.C. § 1381 (providing SSI was designed "[f]or the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled"). In some states, the new federal payment was less than what the now-superseded state programs offered recipients. *Schweiker*, 655 F.2d at 404. Congress, therefore, required states that provided a higher level of assistance to make supplemental payments "[i]n order to ensure that no one suffered as a result of the new program." *Id.* To enforce this requirement, Congress conditioned Medicaid eligibility on a state's agreement to fill any shortfall between the federal SSI benefit and the amount a beneficiary received from a state program. *Id.*

Oklahoma challenged this requirement, as well as a separate federal condition on the receipt of Medicaid funds that required states to agree to pass through to SSI recipients the full amount of annual federal cost-of-living increases. The D.C. Circuit upheld both sets of conditions, holding that Congress had the right to "set conditions on the grant of federal funds." *Id.* at 411. By imposing these restrictions, the court held Congress sought to protect elderly, blind, and disabled beneficiaries from reductions in the real value of their supplemental benefits resulting both from the transition from state programs to the federal SSI program, and from many states' failure to pass through SSI cost-of-living increases. Through both conditions, Congress sought to further the federal interest of ensuring that needy Americans received sufficient financial support. In comparison, Congress, through the ACA, has attempted to ensure that needy individuals just above the poverty line have access to health care. The federal interest in both cases is similar: protecting the basic welfare of the nation's neediest citizens. Just as the D.C. Circuit upheld the challenged federal conditions in *West Virginia*, this Court should uphold the ACA.

Finally, multiple Courts of Appeals have rejected challenges to the federal government's conditioning of Medicaid funds on a state's agreement to provide emergency medical services to undocumented immigrants. *See, e.g., Texas v. United States*, 106 F.3d 661, 666 (5th Cir. 1997); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997); *Padavan v. United States*, 82 F.3d 23, 29 (2d Cir. 1996). Under Medicaid, a state must provide care and services necessary to treat emergency medical conditions of aliens not lawfully admitted for permanent residence and not otherwise permanently residing in the United States. 42 U.S.C. § 1396b(v)(2); *see also* H.R. Rep. No. 99-1012, at 399-400 (1986) (Conf. Rep.) (discussing Congress's enactment of this provision). The Second, Fifth, and Ninth Circuits disagreed that this condition represented unconstitutional coercion, reasoning that the states voluntarily choose to participate in Medicaid and, for this reason alone, are required by the federal government to provide aliens with emergency medical care. *Texas*, 106 F.3d at 666; *California*, 104 F.3d at 1092 (citing *Padavan* on the coercion theory); *Padavan*, 82 F.3d at 29.

Congress sought to ensure that the most vulnerable members of society receive access to health care at critical moments by requiring states with Medicaid programs to provide emergency medical care to undocumented immigrants. Through the ACA, Congress worked to advance this "national project" by protecting another group of highly vulnerable individuals—those with incomes just above the poverty line, and particularly the uninsured among them. If anything, Congress's imposition of conditions on Medicaid funds under the ACA is more closely related to the pursuit of the general welfare and a national project of high importance than the previous emergency medical care expansion, given that the ACA extends full Medicaid coverage and services to a broader range of individuals. This Court should follow the multiple Circuit Courts that have upheld previous Medicaid conditions and uphold the ACA as a proper exercise of congressional authority to attach conditions to Medicaid funds.

II. THE ACA'S MEDICAID EXPANSION IS NOT COERCIVE

A. The ACA Provided the States with Significant Funds to Cover the Cost of Expanding Medicaid

Congress assumed much of the cost of the ACA's expanded Medicaid coverage. The federal government will assume 100% of the costs associated with the Medicaid expansion for the first three years of the new program. Federal support will decrease slightly so that by 2020 and thereafter, the federal government will be responsible for roughly 90% of the costs of covering individuals made eligible for Medicaid as a result of the ACA. The Court should reject Petitioners' argument, which appears to be that the complete federal subsidy of the first three years makes acceptance of the longer term Medicaid expansion too tempting for the states to pass up. By any reasonable definition that is not coercion.

B. The ACA's Medicaid Expansion Is Exactly the Sort of Program Held Non-Coercive in Prior Cases

Petitioners' coercion argument concedes that the federal government may condition a grant of funds to a state on the latter's adoption of particular legislation, assuming the other requirements under the Spending Clause are met, which here they undisputedly are. Brief of State Petitioners on Medicaid at 22 (hereinafter "State Brief") (acknowledging that the provisions of ACA giving states the option to either accept federal exchanges or set up their own are constitutional); *Id.* at 37-38 (acknowledging that Medicaid expansions that conditioned only new federal money would be constitutional). However, when the funds that would be withheld from a state for noncompliance are sufficiently sizable, Petitioners contend that this same procedure becomes unconstitutionally "coercive." A difference of degree assertedly becomes a difference of kind, and there is no apparent reason Petitioners' argument would only apply to subsequent changes and not every time Congress crafts a joint program, funds it generously, and includes numerous standards that it deems appropriate.

Petitioners can point to no precedent supporting their proposition, only dicta raising the issue in two cases, *South Dakota*, 483 U.S. 203, and *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937). As the Eleventh Circuit noted in rejecting this same argument, no case has ever struck down an act of Congress as unconstitutionally coercive under the Spending Clause. *Florida, et al., v. Dep't of Health and Human Servs. et al.* 648 F.3d 1235, 1266 (11th Cir. 2011). Cases applying the Tenth Amendment's prohibition on commandeering state government have all involved federal statutes that directly compelled a state to act or purported to "exclu[de] . . . the state from otherwise lawful activity." *College Sav. Bank v. Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999); *Printz v. United States*, 521 U.S. 898, 923-24 (1997); *New York v. United States*, 505 U.S. 144, 176-77 (1992). This Court has never held that a difference in the amount (of conditioned funds) rises to the level of a difference of kind in a context like this one.

To the contrary, as discussed above, the Court and numerous lower courts have approved prior instances where Congress conditioned continued participation in the entirety of Medicaid on acceptance of a particular expansion or modification of the program. *See also Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990) (Medicaid is an entirely voluntary "cooperative federal-state program through which the Federal Government provides financial assistance to the States. . . ."). As with those decisions, this Court should reject Petitioners' coercion argument here.

C. The Court Should Decline Petitioners' Invitation to Expand the Definition of "Coercion" Because None of the Asserted Rationales for the Coercion Doctrine Apply

Even assuming that a large enough potential loss of federal funding could alone constitute "coercion," this Court still ought not craft a standard that would encompass this case. The Petitioners argue that a conditional federal grant is coercive if it is "so great and important to the state's integral function . . . as to compel the state to participate in the 'optional' legislation." Petition for Writ of Certiorari at 20, *quoting Florida*, 648 F.3d at 1267. Yet the provision of health insurance to those unable to obtain it in the private marketplace cannot be an "integral function" of the states, because the states have rarely offered such coverage independent of the federal government, and have (with few and limited exceptions) failed to insure the very populations brought into Medicaid by the ACA.

The Petitioners suggest that the withdrawal of all federal Medicaid funds provided for in the ACA would force them to provide a program that would perform Medicaid's functions. State Brief at 23. As a legal matter, this is indisputably incorrect. *See DeShaney v. Winnebago County Dep't of Social Servs.*, 489 U.S. 189, 196-97 (1989) ("[T]he Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual"). Indeed, any such conclusion is foreclosed by Petitioners' own argument. Providing a program to cover those outside Medicaid is exactly what the state Petitioners contend they are not obligated to do with respect to the intended recipients of the ACA Medicaid expansion. Petitioners do not suggest any constitutional distinction between the present Medicaid population and the expanded Medicaid population under the ACA. It is inconsistent for Petitioners to argue in one breath that the federal government is forbidden to incentivize them to cover one group of citizens, and in the next breath that the potential withdrawal of federal funds is coercive because the states are obligated to cover another group of citizens.

This contradiction is not merely a matter of logical inconsistency. From the perspective of *Amici* as caregivers, the Petitioners' argument uses the legal concept of "coercion" in a way that is divorced from the real-world consequences of the Medicaid expansion. The Petitioners portray an overwhelmingly federally-funded extension of care to those unable to obtain it otherwise as a threat to cripple the states. The premise of their argument is that the states' moral obligation to care for the neediest is so compelling that they must avoid the withdrawal of the federal government funds they need, or prefer to use, for that purpose. Yet the reality is that Petitioners have never recognized nor fulfilled any such obligation. This amounts to asserting a right to coerce Congress to keep funding states that reject standards of participation Congress has found to be appropriate to its balancing of competing interests and its own limited resources.

For the uninsured served by *Amici*, Medicaid presents a critical lifeline to which there is no feasible alternative. *Amici* believe they have a moral obligation to provide care where the states have failed to do so. That is precisely why *Amici* and other Catholic Sisters lobbied so hard for passage of the ACA Medicaid expansion.

Petitioners cloud the issue when they try to foreclose consideration of the degree of benefit offered. This ignores the reality that what makes it difficult for Petitioners to now choose to reject the Medicaid "deal" is not federal coercion but Medicaid's overall attractiveness—effectiveness at low cost to the states—despite certain standards of participation with which they disagree. The ACA Medicaid provisions represent an extraordinarily generous expansion of coverage funded almost entirely by the federal government, which requires only a small contribution from the states. While many more of the states' residents will be covered, the program will cost the states little or nothing for three years, followed by a contribution that gradually rises to just 10%.

Petitioners contend that a holdup for $5 is no less coercive than a holdup for $5000. But the analogy here is to a "holdup" where the federal government asks for a small percentage of matching funds years from now, so long as the states allow it to give them each $100 for the next three years, then $95 for a couple of years, and $90 for every year after. The Petitioners may respond that coercion is still coercion, whatever the amount of the stickup, but they themselves have already admitted that degree matters. It is the premise of their entire argument.

D. The Expansion of Medicaid Increases States' Flexibility to Tailor Healthcare Efforts

Not only is the ACA's expansion of Medicaid not unduly coercive on the states, but it will increase the states' flexibility with regard to the provision and administration of healthcare. Although Petitioners argue that the expansion of Medicaid infringes upon Tenth Amendment rights reserved to the states, they leave out a key fact in their analysis: the states actually want Medicaid. State Brief at 23. Without a Medicaid-like program, the states admit they would still want to provide healthcare services for their neediest citizens—even though there is no constitutional requirement that they do so—and probably would substantially raise taxes or cut other types of funding to achieve this. *Id.* While *Amici* agree that the states should be morally compelled to provide their neediest citizens with access to healthcare if the states refuse federal funds, they write to emphasize that this would leave states with much less flexibility to use state funds in other ways.

Indeed, the state-federal partnership model, of which Medicaid is the largest-scale example, allows the federal government to help states achieve their goals with regard to citizens' health while preserving the states' ability to determine many facets of administration and implementation. It is an example of "a program of cooperative federalism." *New York v. United States*, 505 U.S. at 167 (1992) (quoting *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 288 (1981)). And the ACA is hardly the first law Congress has passed with this state-federal scheme in mind.[5] A state may choose to decline participation in the state-federal partnership if the states' residents and their representatives disagree with what the federal policy is trying to accomplish. States may also decline federal money and use their own taxing power to create a program better suited to their needs. That this is difficult to do because there is limited money to go around does not change the constitutional posture of the case; state budgets are now and have always been limited, and there are always difficult decisions to be made. This is why state residents elect the representatives they believe will best allocate state resources. And this is why the federal government's offer to provide 100% of the initial funding to expand Medicaid to more state residents is a great deal that gives states the flexibility to deal with what all agree is a staggering nationwide problem. 42 U.S.C. § 1396(a). With the expansion of Medicaid, states will have more of their needy residents receiving crucial healthcare services while paying nothing for these services initially and only 10% later. Nat'l Ass'n of State Budget Officers, *2010 State Expenditure Report: Examining Fiscal 2009-2011 State Spending*, at 44 (2011).[6]

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[5] Myriad examples of federal-state partnerships reflect the acceptance of the right of the federal government to address what federal and state governments agree is a shared problem with a shared objective. *See, e.g.*, Clean Water Act, 86 Stat. 816, as amended, 33 U.S.C. § 1251 *et seq*.; Occupational Safety & Health Act of 1970, 84 Stat. 1590, 29 U.S.C. § 651 *et seq*.; Resource Conservation & Recovery Act of 1976, 90 Stat. 2796, as amended, 42 U.S.C. § 6901 *et seq*.; Alaska National Interest Lands Conservation Act, 94 Stat. 2371, 16 U.S.C. § 3101 *et seq*.

[6] Available at http://nasbo.org/.

Furthermore, the many health problems Americans increasingly confront—obesity, heart disease, high blood pressure, diabetes—often result in emergency room visits and medical services for which the recipients never end up paying. *See* Richard Niska et al., National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary, National Health Statistics Reports, No. 26 at 3 (Aug. 6, 2010).[7] Currently, states have little choice; they must simply accept that many low-income individuals use emergency services and do not pay, leaving service providers unpaid and raising costs for everyone in return. *Id.* By expanding Medicaid to cover uninsured, low-income adults, the states will have far more flexibility in how they manage this population. Rather than the reactionary approach states have had to take with the provision of emergency services, Medicaid expansion will allow states to create prophylactic plans for medical care. The residents formerly relegated to emergency room visits can instead be sent to primary care providers, in offices, clinics, or hospitals, who can both provide preventive services to help avert major health problems, and can avoid the extra expense associated with emergency room visits. States will be left with actual choices with regard to how to structure the provision of healthcare services to their citizens.

In our system of federalism, the federal and state governments are not exclusive, conflicting entities. State governments represent state citizens, but the federal government also represents those citizens. The state petitioners essentially argue that the federal government is taking away states' right to provide healthcare to their citizens as they wish. State Brief at 24. But Congress consists of representatives of states, elected by the citizens of those states, sitting as one body to represent the national interest. The state-by-state and district-by-district formation of Congress ensures a natural check within the federal government to ensure that states' interests are represented.

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[7] *Available at* http://www.cdc.gov/nchs/data/nhsr/nhsr026.pdf.

In this case, twenty-six states are suing the federal government, and yet these states had representation in Congress just as the twenty-four states that do not contest this law, and apparently see no threat to their sovereignty. If some citizens of half the states think they know better than the majorities in Congress as to how best to structure affordable health care, the solution is not to declare the law unconstitutional; it is to engage in representative democracy. ACA's expansion of Medicaid represents a national endeavor to address the critical health care insurance crisis, and the Court should uphold it as such.

CONCLUSION

For the foregoing reasons, this Court should affirm the decision of the Court of Appeals that the ACA's Medicaid expansion provisions do not unconstitutionally coerce states.

Respectfully submitted,

David J. Burman
Counsel of Record
PERKINS COIE LLP
1201 Third Avenue, Suite 4800
Seattle, WA 98101-3099
(206) 359-8426
DBurman@perkinscoie.com

Joren S. Bass
Kenneth J. Halpern
Euphemia N. Thomopulos
Alan Murphy
Anahit Samarjian
PERKINS COIE LLP
4 Embarcadero Center
Suite 2400
San Francisco, CA 94111-4131
(415) 344-7000

Counsel for Amici Curiae

February 17, 2012

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Appendix A: List of *Amici Curiae*. 1a

APPENDIX A

List of *Amici Curiae*

Margaret Byrne, CSJP
Sisters of St. Joseph of Peace

Simone Campbell, SSS
NETWORK

Janice Cebula, OSF
Sisters of St. Francis, Clinton, Iowa

Nancy Conway, CSJ
Congregation of the Sisters of St. Joseph

Jacquelyn Doepker, OSF
Sisters of St. Francis of Tiffin, Ohio

Gemma Doll, OP
Dominican Sisters of Peace

Rose Mary Dowling, FSM
Franciscan Sisters of Mary

Patricia Farrell, OSF
Leadership Conference of Women Religious

Mary Genino, RSHM
Religious of the Sacred Heart of Mary,
Western American Province

Gladys Guenther, SHF
Sisters of the Holy Family

Beatrice Haines, OLVM
Our Lady of Victory Missionary Sisters

Mary Ellen Holohan, SNJM
Sisters of the Holy Names Province
Leadership Team

Gloria Marie Jones, OP
Dominican Sisters of Mission San Jose

Attracta Kelly, OP
Adrian Dominican Sisters

Patricia McDermott, RSM
Sisters of Mercy of the Americas

Joan Mumaw, IHM
Leadership Council, Sisters, Servants of the
Immaculate Heart of Mary (Monroe)

Mary Pellegrino, CSJ
Sisters of St. Joseph of Baden

Mary Rehmann, CHM
Congregation of the Humility of Mary,
Davenport, Iowa

Theresa Sandok, OSM
Servants of Mary, Ladysmith, Wisconsin

Nancy Schreck, OSF
Sisters of St. Francis, Dubuque, Iowa

Mary Ann Zollmann, BVM
Sisters of Charity of the Blessed Virgin Mary

AMICUS CURIAE BRIEF

No. 11-400

In the

Supreme Court of the United States

STATES OF FLORIDA, et al.,

Petitioners,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES , et al.,

Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* CENTER FOR CONSTITUTIONAL JURISPRUDENCE, PACIFIC LEGAL FOUNDATION, CATO INSTITUTE, CONGRESSMAN DENNY REHBERG AND DR. JEFF COLYER IN SUPPORT OF PETITIONERS

(MEDICAID SPENDING/COERCION ISSUE)

EDWIN MEESE III
214 Massachusetts Ave. N.E.
Washington D.C. 20002

TIMOTHY SANDEFUR
Pacific Legal Foundation
930 G Street
Sacramento, CA 95814

ILYA SHAPIRO
Cato Institute
1000 Mass. Ave., N.W.
Washington, D.C. 20001

JOHN C. EASTMAN
Counsel of Record
ANTHONY T. CASO
KAREN J. LUGO
Center for Constitutional
Jurisprudence
c/o Chapman Univ. Sch. of Law
One University Drive
Orange, California 92886
(714) 628-2587
jeastman@chapman.edu

Counsel for Amici Curiae

QUESTION PRESENTED

1. Against the backdrop of a federal spending program the constitutionality of which is both dubious and untested, does Congress exceed its enumerated powers and violate basic principles of federalism when it coerces States into accepting onerous conditions that it could not impose directly by threatening to withhold all federal funding under the single largest grant-in-aid program, or does the limitation on Congress's spending power that this Court recognized in *South Dakota v. Dole*, 483 U.S. 203 (1987), no longer apply?

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INTEREST OF AMICI CURIAE[1]

Amicus the Center for Constitutional Jurisprudence was established in 1999 as the public interest law arm of the Claremont Institute, the mission of which is to uphold and restore the principles of the American Founding to their rightful and preeminent authority in our national life, including the foundational proposition that the powers of the national government are few and defined, with the residuary of sovereign authority reserved to the states or to the people. In addition to providing counsel for parties at all levels of state and federal courts, the Center and its affiliated attorneys have participated as amicus curiae or on behalf of parties before this Court in several cases addressing the constitutional limits on federal power, including *American Elec. Power Co., Inc. v. Connecticut*, 131 S.Ct. 2527 (2011); *Bond v. United States*, 131 S.Ct. 2355 (2011); *Reisch v. Sisney*, No. 09-953, *cert. denied*, 130 S.Ct. 3323 (2010); *Rapanos v. United States*, 547 U.S. 715 (2006); *Solid Waste Agency of Northern Cook County v. U.S. Army Corps of Engineers*, 531 U.S. 159 (2001); *Schaffer v. O'Neill*, No. 01-94, *cert. denied*, 534 U.S. 992 (2001); and *United States v. Morrison*, 529 U.S. 598 (2000).

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[1] Pursuant to this Court's Rule 37.2(a), all parties have consented to the filing of this brief. Letters evidencing such consent have been filed with the Clerk of the Court. Pursuant to Rule 37.6, *Amici Curiae* affirm that no counsel for any party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *Amici Curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

Amicus Pacific Legal Foundation ("PLF") is widely recognized as the largest and oldest nonprofit legal foundation representing the views of thousands of supporters nationwide who believe in limited government, individual rights, and federalism. PLF has participated as amicus curiae in several lawsuits challenging the constitutionality of the Patient Protection and Affordable Care Act (PPACA), including *Virginia ex rel. Cuccinelli v. Sebelius* (No. 11-420, pending); *Seven-Sky v. Holder*, 661 F.3d 1 (D.C. Cir. 2011); and *Coons v. Geithner*, No. CV-10-1714 (D. Ariz., pending). In addition, PLF attorneys represent amicus Matthew Sissel, a citizen of Iowa, and decorated Iraq War veteran and small business owner, who is the plaintiff in a lawsuit challenging the constitutionality of PPACA, *Sissel v. U.S. Dep't of Health & Human Servs.*, No. 1:10 cv 01263 RJL (D.D.C., filed July 26, 2010).

Amicus Cato Institute was established in 1977 as a nonpartisan public policy research foundation dedicated to advancing the principles of individual liberty, free markets, and limited government. Cato's Center for Constitutional Studies was established in 1989 to help restore the principles of limited constitutional government that are the foundation of liberty. Toward those ends, the Cato Institute publishes books and studies, conducts conferences and forums, publishes the annual *Cato Supreme Court Review*, and files *amicus* briefs. The instant case concerns Cato because it raises vital questions about federalism and individual liberty.

Amicus Congressman Denny Rehberg of Montana is a Member of the One Hundredth and Twelfth Congress and currently serves as Chairman of the

Appropriations Subcommittee on Labor, Health and Human Services, Education & Related Agencies, which Subcommittee has partial jurisdiction over Medicaid expenditures and operations. Congressman Rehberg takes seriously his independent duty as a Member of Congress and as Subcommittee Chairman to ensure that the Constitution is upheld, in keeping with his oath of office. He has consistently opposed the Patient Protection and Affordable Care Act from the time of its initial consideration by Congress and has led or participated in efforts in the House of Representatives to defund, amend and repeal the Act on constitutional and other grounds.

Amicus Jeff Colyer is a practicing physician and the Lieutenant Governor of the State of Kansas. As Lieutenant Governor Dr. Colyer oversees Kansas's Medicaid program and believes the PPACA unconstitutionally encroaches on the sovereignty of the state of Kansas by coercively requiring Kansas to adopt Medicaid policies that are not in the interests of the citizens of Kansas.

SUMMARY OF ARGUMENT

California risks losing $25.6 billion in federal funding annually—one quarter of its entire general-fund revenue budget—if it does not acquiesce in the new expansions to Medicaid coverage mandated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 ("ACA"). Arizona risks losing $6.3 billion, and would have to increase its own annual general revenues by an astounding 67% in order to replace the federal share of funding for the existing Medicaid program if it does not yield to the new law's expansion demand. Collectively, the

States stand to lose more than a quarter trillion in existing federal funding annually, more than 25% of their total general revenue budgets, and would on average have to increase their general revenue budgets by 39.7% in order to maintain the existing level of Medicaid funding for their citizens. *See* Edmund F. Haislmaier, *Quantifying Costs to States of Noncompliance with PPACA's Medicaid Expansion*, Backgrounder No. 2640 (Heritage Foundation, Jan. 12, 2012).[2] If penalties of that magnitude do not cross the line from "inducement" to "coercion" and trigger the anti-coercion prong of this Court's Spending Clause analysis in *South Dakota v. Dole*, 483 U.S. 203 (1987), nothing ever will.

Beyond the sheer magnitude, there is something deeply troubling, from a structural federalism perspective, about a federal government grown so large that it can take over entire swaths of the States' police power under the guise of conditions on federal spending. The concerns raised in Congress about the constitutionality of the federal government's first foray into the social welfare arena demonstrate that the authority was seen as much narrower than many now believe. But what began with the small step of upholding a federal program to stop the "spread" of Depression-era unemployment from State to State has now metastasized into wholesale usurpation of the police power—that power to regulate the health and safety of the people which this Court has correctly and repeatedly recognized is reserved to the

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[2] Available at http://www.heritage.org/research/reports/2012/01/quantifying-costs-to-states-of-noncompliance-with-the-ppacas-medicaid-expansion (last visited Jan. 13, 2012).

States. Just as the Commerce Clause has outer limits—and we fully endorse the holding of the Eleventh Circuit below on that score—the Spending Clause also has limits that must be enforced. *United States v. Butler*, 297 U.S. 1 (1936). Each of the prongs of the *Dole* analysis must therefore be given effect, and all of them must be developed against the premise of limited, enumerated federal powers.

ARGUMENT

I. THE AFFORDABLE CARE ACT UNCONSTITUTIONALLY COERCES STATES TO IMPLEMENT THE FEDERAL GOVERNMENT'S MEDICAID EXPANSION

A. The Coercion Prong of the *Dole* Spending Clause Analysis Must Be Given Effect.

Ever since this Court recognized in *South Dakota v. Dole* that conditional federal spending could cross the line from permissible inducement to unconstitutional coercion, 483 U.S. at 211, lower courts have struggled to apply that principle. Some have even found it hard to understand how any "gift" of funds, viewed in isolation, could be coercive. *See, e.g.*, *Nevada v. Skinner*, 884 F.2d 445, 448–49 (9th Cir. 1989); *Kansas v. United States*, 214 F.3d 1196, 1202 (10th Cir. 2000).

But the "coercion" prong should not be viewed in isolation. It exists against a backdrop of a limited spending power, and in the context of federalism. Where, as with the case of the expanded Medicaid program under consideration here, the federal government grabs tax revenues from a State's own citizens, then returns some portion of those revenues to further police power purposes that fell within the State's jurisdiction in the first place, meanwhile attaching to that "gift" some regulatory condition that the federal government lacks power to impose directly, the transaction is inherently coercive. *See* Richard Epstein, *Bargaining With the State* 152 (1993); Lynn A. Baker, *The Spending Power and the Federalist Revival,* 4 Chap. L. Rev. 195, 212 (2001). As this Court recognized in *Butler*, "[t]here is an obvious difference between a statute stating the conditions upon which moneys shall be expended and one effective only upon assumption of a contractual obligation to submit to a regulation which otherwise could not be enforced." 297 U.S. at 73. "[I]f, in lieu of compulsory regulation of subjects within the States' reserved jurisdiction, which is prohibited, the Congress could invoke the taxing and spending power as a means to accomplish the same end," the spending power "would become the instrument for total subversion of the governmental powers reserved to the individual states." *Id.* at 75.

Yet that is exactly what the ACA does. Title II of the ACA requires states to expand Medicaid coverage to millions of people who are not now covered: all people under the age of 65 whose annual household income is below 138 percent of the federal poverty level, currently about $30,000 for a family of four, excluding non-cash welfare assistance from programs such as public housing and food stamps (which can add $10,000 or more to the equation), income from capital gains, income from unrelated housemates, and the value of other assets or resources. *See* ACA §§ 2001(a)(1)(C), 2002(a)(14)(C); 42

U.S.C. §§ 1397jj(c)(5), 9902(2); *see also* U.S. Census Bureau, *How the Census Bureau Measures Poverty.*[3] It also mandates a floor for coverage of all existing Medicaid recipients, and even locks in higher levels of benefits in States that had already voluntarily exceeded that floor. ACA §§ 2001(a)(2), 1501(b), 2001(b).

The federal government could not simply *command* the states to adopt these expansive Medicaid programs. That would amount to "commandeering" of the legislative policy judgment of the states, in violation of the Tenth Amendment. *See New York v. United States*, 505 U.S. 144, 161 (1992); *Hodel v. Virginia Surface Mining & Reclamation Ass'n.*, 452 U.S. 264, 288 (1981); *cf. Printz v. United States*, 521 U.S. 898, 933 (1997). Yet when conditions on federal spending are used, as here, to accomplish the same commandeering end (rather than simply insuring that the federal monies be spent for their intended purposes), the intrusion on States' sovereign authority is no less palpable, and the Tenth Amendment violation no less clear.

The coercion prong of the *Dole* analysis was apparently designed, and certainly is well-suited, to prevent the federal government from doing by indirection what it cannot do directly. It must be given effect by this Court in order to ensure that the lines of demarcation between the state and federal governments are protected.

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[3] Available at http://www.census.gov/hhes/www/poverty/about/overview/measure.html (last visited Jan. 14, 2012).

B. The ACA Violates the Prohibition Against Coercive Conditional Spending.

The need for a vigorous anti-coercion jurisprudence is particularly evident where, as here, the amount States risk losing if they do not acquiesce in the new mandate is massive and amounts to a large percentage of the total funds the States receive from the federal government. *See Com. of Va. Dept. of Educ. v. Riley*, 86 F.3d 1337, 1356 (4th Cir. 1996) (Luttig, J., dissenting), *adopted as the plurality opinion of the court on reh'g en banc*, 106 F.3d 559 (4th Cir. 1997) (holding that "a Tenth Amendment claim of the highest order lies" where the Federal Government "withholds the entirety of a substantial federal grant on the ground that the State refuses to . . . submit to the policy dictates of Washington in a matter peculiarly within their powers as sovereign States.").

A recent study by the Heritage Foundation exposes the magnitude of the "coercion" problem confronted by the States here. The projected federal share of Medicaid grants to the States in the coming fiscal year is $256.9 billion, more than a third of cumulative State general fund revenues. The federal share of Medicaid spending in California next year will be $25.6 billion, roughly a quarter of the State's $105 billion general-fund revenue budget. $31.5 billion is the amount in New York; $17.8 billion in Texas; $12.3 billion in Pennsylvania; $5.3 billion in Louisiana. The increase in State general-fund revenues needed to replace those federal funds ranges from

20.44 percent in New Jersey[4] to a staggering 67.26 percent in Arizona, with an average of 39.7 percent. *See* Haislmaier, *supra* at 3.

Were any State to decline to participate in the new, expansive Medicaid program, it would lose these funds, unaccompanied by any reduction in the share of the federal tax burden borne by the State's own citizens. As in *Butler*, such a condition "is not in fact voluntary. The [State], of course, may refuse to comply, but the price of such refusal is the loss of benefits.... This is coercion by economic pressure. The asserted ... choice is illusory." 279 U.S. at 70-71.

In a perfect world, the States would never have become so dependent on federal Medicaid spending in the first place. In the first seventy years of our nation's history, presidents routinely vetoed federal appropriations for matters falling within the internal affairs of the States as a "fatal encroachment" upon the states that would create a "danger of consolidation" in the national government. Veto Message of President Polk, 43 H.R. Journal 82, 93 (1847); *see also, e.g.*, 30 Annals of Congress 212 (Madison); 39 Annals of Congress 1838, 1849 (Monroe).

President Jackson called the notion that Congress could spend money within the States for whatever it determined to be conducive to the general welfare a "dangerous doctrine," a "fallacy" that overlooked "the great considerations in which the federal government was founded," namely, that the States did "not consent to make a grant to the Federal Government of the general and usual powers of Government, but of such only as were specifically enumerated." 28 H.R. Journal 28 (1834). Such a system would be harmful to the federal government, President Polk subsequently noted, because it would "absorb the revenues of the country, and plunge the government into a hopeless indebtedness." 43 H.R. Journal 85 (1847).

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[4] Excluding Alaska, which for reasons peculiar to itself, is an outlier at 9.88%.

More significantly, as President Buchanan recognized, federal funding for matters of state concern would "break down the barriers which have been so carefully constructed in the Constitution to separate the Federal from State authority," causing "an actual consolidation of the Federal and State Governments . . . , equally ruinous to both." 55 H.R. Journal 505-06 (1859). It "would operate with equal detriment to the best interests of the States," he added, because "[i]t would remove the most wholesome of all restraints on legislative bodies—that of being obliged to raise money by taxation from their constituents—and would lead to extravagance, if not corruption." *Id.* at 504.

Instead, the States have clearly become so dependent on federal spending that they are deprived of any real choice in the decision whether to obey the ACA's mandated expansion. As this Court has previously acknowledged, "a complete withdrawal of the federal prop in the system . . . could seriously cripple a state's attempts to provide other necessary medical services" to its residents. *Harris v. McRae*, 448 U.S. 297, 309 n.12 (1980) (internal citation and quotation marks omitted).

States are simply addicted to the existing federal spending, and, like any addict, they increasingly find themselves accepting any conditions that the federal government retroactively imposes in order to get continued access to the federal financial fix. And the Government is the pusher who defends himself by claiming the user is a voluntary buyer. The first hit is always free, but the customers must keep coming back, sometimes doing unspeakable things just to get a fix. *See, e.g.*, *United States v. Saunders*, 943 F.2d 388 (4th Cir. 1991) (upholding rape conviction against defense that the woman had a habit of trading sex for drugs); *cf.* Catharine MacKinnon, "Trafficking, Prostitution, and Inequality," 46 Harv. C.R.-C.L. L. Rev. 271, 287 (2011).

The States are thus commandeered to do the federal government's bidding, and the sheer mass of the command makes Title II of the ACA more vulnerable to attack than the modest programs that were invalidated in both *New York* and *Printz.* It also explains why this case is easily distinguishable from the two precedents on which the government relies. The modest five percent of federal highway funds at issue in *Dole* that would be withheld from any State for refusing to raise its drinking age to 21 was a mere pinprick in the side of State government. The federal tax on employers upheld in *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937), did not pose nearly the same threat to the States because it preserved their autonomy to establish their own unemployment-compensation programs, by refunding 90 percent of the tax to employers located in any State that established its own program to achieve that end.

But the size of the federal penalty for non-acquiescence here is only half the problem. If a State had the temerity to go cold turkey on the federal spending and withdraw from the Medicaid system entirely, the federal tax burden would still be imposed on the State's citizens to fund the nationwide system of Medicaid for everyone else, effectively precluding the State from imposing taxes sufficient to maintain its current level of medical services for its own citizens while discharging its other obligations.

Even if a State did have an untapped tax base substantial enough to create a substitute system for indigent medical care, it would run into other federal barriers. The 1986 Emergency Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, effectively prevents any State from re-establishing a system of county hospitals for the indigent of the sort that was once highly successful. *See* Jeffrey A. Singer, M.D., *Why Medicaid is No Longer a Voluntary Program*, Reason.com (Dec. 30, 2011).[5] EMTALA forbids private hospitals from transferring indigent, uninsured patients to county hospitals in most circumstances. 42 U.S.C. § 1395dd(c)(1).

In sum, the ACA demands from the States a massive expansion in Medicaid coverage, on pain of losing so much federal funding that refusal is not a real option.

C. Notions of "Political Process Federalism" Cannot Salvage the ACA.

The notion of "political process federalism," adopted by a closely-divided Court in *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985), does not rescue the ACA from this problem of unconstitutional coercion for at least two reasons. First, the Court has not applied the "political process federalism" idea in commandeering cases. In *New York v. United States,* for example, this Court expressly disclaimed reliance on *Garcia*, noting that the anti-commandeering challenge at issue in that case presented "no occasion to apply or revisit the holdings of any of these cases [including *Garcia*], as this is not a case in which Congress has subjected a State to the same legislation applicable to private parties." 505 U.S. at 160. And in *Printz,* the Court rebuffed the "political process federalism" challenge that was strenuously pressed by Justice Stevens in dissent. Instead, the Court noted that "the very *principle* of separate state sovereignty" is offended by federal laws that commandeer state officials, and that "the courts have traditionally invalidated measures deviating from" the form of government set forth in the Constitution, including the division of power among federal and state sovereigns. 521 U.S. at 932-33 (quoting, *inter alia*, *New York*, 505 U.S. at 187); *id.* at 956 (Stevens, J., dissenting).

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[5] Available at http://reason.com/archives/2011/12/30/why-medicaid-is-no-longer-a-voluntary-pr (last visited Jan. 14, 2012).

Second, even if the line of demarcation between State as regulated entity and State as commandeered agent of the federal government were not an absolute bar to a "political process federalism" defense for the ACA, the cavalier way in which Congress treated its existing processes in order to push the ACA through demonstrates beyond peradventure that "political process federalism" is an insufficient substitute for judicial review in protecting basic federalism principles.

The abuse of process leading up to the passage of the ACA is notorious. The bill was pushed through the Senate in a rare Christmas-Eve vote in 2009,[6] after the final votes necessary for passage were essentially "bought" with egregious provisions that violated the most basic premise that "law" is to be generally applicable.[7] Nebraska's senior Senator, for example, obtained for his State a guarantee, dubbed the "Cornhusker kickback," that the federal government would pay the full cost of expanded Medicaid coverage for Nebraska in perpetuity, a guarantee not accorded any other state. ACA, P.L. 111-148, 124 Stat. 119, §10201(c)(4)(z)(3).[8]

Moreover, unlike previous efforts at major social legislation, this one was approved on a straight, party-line vote in the Senate, and a nearly straight party-line vote in the House.[9] The normal process of reconciling the Senate bill with an earlier, different version adopted by the House of Representatives was cast aside when a special election in Massachusetts resulted in the election of a new Senator who had campaigned to be the vote necessary to stop passage of the bill. House leaders then trolled for mechanisms that would allow the final bill to be adopted without having to return for a second vote in the Senate or requiring House members cast a vote in favor of the objectionable parts of the Senate bill. At one point, the House even proposed simply "deeming" the Senate bill passed without actually holding a vote.[10] Ultimately, the Senate version of the bill was passed by the House, with the necessary votes secured by an arguably unconstitutional promise by the President not to enforce one of the provisions that was objectionable to some of those who otherwise supported the bill,[11] and a promise of "amendments" that would be classified as a "reconciliation" bill in order to circumvent Senate cloture rules.[12]

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[6] Robert Pear, *Senate Passes Health Care Overhaul on Party-Line Vote*, N.Y. Times at A1 (Dec. 24, 2009), available at http://www.nytimes.com/2009/12/25/health/policy/25health.html (last visited Jan. 14, 2012).

[7] *The Price is Right? Payoffs for Senators Typical in Health Care Bill*, FoxNews.com (Dec. 21, 2009), available at http://www.foxnews.com/ politics/2009/12/21/price-right-payoffs-senators-typical-health-care/ (last visited Jan. 14, 2012).

[8] *See also* Greg Hitt and Janet Adamy, *Senate Democrats Clear Health Hurdle*, Wall St. J. A7 (Dec. 22, 2009). Available at http://online.wsj.com/article/SB126132489013599195.html (last visited Jan. 14, 2012).

[9] Pear, *supra* n. 6, at A1.

It may be true, as Bismarck reputedly remarked, that laws are like sausage—it is better not to see them being made. But the abusive process outlined above really undermines the "political process federalism" argument. A principle as fundamental as federalism should never be left to such cavalier disregard for existing processes. It requires the active defense by this Court, particularly when the legislation involved significantly transforms the federal-state relationship. Even had Congress developed a broad-based consensus to support a massive Medicaid expansion, it could not commandeer the States to be its wards. The federalist form of our government matters. As this Court observed in *New York*, "the Constitution protects us from our own best intentions: it divides power among sovereigns . . . precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day." 505 U.S. at 187.

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[10] Adam Nagourney, *Procedural Maneuvering and Public Opinion*, N.Y. Times at WK1 (March 21, 2010), available at http://www.nytimes.com/2010/03/21/weekinreview/21nagourney.html?ref=healthcarereform (last visited Jan. 14, 2012).

[11] Lori Montgomery and Shailagh Murray, *In Deal with Stupak, White House announces executive order on abortion*, Wash. Post (March 21, 2010), available at http://voices.washingtonpost.com/44/2010/03/white-house-announces-executiv.html (last visited Jan. 14, 2012).

[12] Gail Russell Chaddock, *Republicans rage against reconciliation for healthcare reform*, Christian Science Monitor (March 3, 2010), available at http://www.csmonitor.com/USA/Politics/2010/0303/Republicans-rage-against-reconciliation-for-healthcare-reform (last visited Jan. 14, 2012).

II. THE SPENDING CLAUSE, LIKE THE COMMERCE CLAUSE, HAS OUTER LIMITS.

The need for a vigorous anti-coercion jurisprudence in the conditional spending arena is even more pronounced here, where the precursor spending programs which the ACA expands were already pushing the constitutional envelope. It is important, therefore, to consider the coercion challenge pressed by the States against the backdrop of Congress' spending authority itself, and the limits on that authority set out in the Constitution.

A. Spending Clause Jurisprudence Since *Butler* Has Not Paid Sufficient Heed to the "Outer Limits" of Constitutional Authority.

The history of Spending Clause jurisprudence since this Court decided *United States v. Butler* in 1936 has been a rather dramatic slippery slope.

With concerns about constitutionality raised repeatedly during the several months of debate, Congress carefully circumscribed the original Social Security program to *augment* rather than supplant state efforts to provide for the unemployed and aged needy. Title I of the Act authorized federal matching grants only to states that had approved old-age assistance plans, for example. The federal grant could only cover fifty percent of the State's expenses, up to a maximum of fifteen dollars per person covered. 79 Cong. Rec. 5469-70 (1935). As noted by Represen-tative Doughton, Chairman of the House Ways and Means Committee and one of the principal co-sponsors of the bill, the matching-grant aspect of the system was designed because Congress recognized that caring for the aged was "primarily a State and local responsibility." *Id.* at 5469 (Statement of Rep. Doughton). State law, not federal law, determined how much aid an individual received in his old-age pension. *Id.* at 5475.

Similarly, Congress set up a matching-grant system for unemployment benefits, and strove to "limit very strictly" the Social Security Board's power over states so as to "provide a maximum of State control." *Id.* at 5469. Likewise, states were generally free to determine the provisions of unemployment benefit programs, including the scale of benefits. *Id.* 5475-76.

Representative Doughton also made a prescient prediction:

> If the Federal Government were to go further and take over the entire problem of old-age pensions, as is advocated by some, it would be contrary to our fundamental political institu-

> tions and would place upon the National Government a tremendous financial burden without the protection of local vigilance which will prevail if local taxpayers are required to bear part of the cost.

Id. at 5470.

In short, Congress itself recognized that while it might encourage state and local efforts to aid dependents, it could not wholly control the process. Creating a national program would violate the American government's federalist structure and, in distancing taxpayers from the process, would be financially unsound.

Opponents of the bill thought these measures were insufficient to render the Act constitutional. It was "generally agreed," noted New York Democratic Senator Robert Wagner, that the General Welfare Clause was "a restriction upon the power to tax rather than an independent grant of legislative authority." 79 Cong. Rec. 9286 (1935). And when it turned to creating a direct federal pension system for the non-"needy," both proponents and opponents seemed to agree that creating a national insurance system would be unconstitutional. Representative Ransley, for example, noted that "there is grave doubt as to the constitutionality of [that] part of the bill; the Government, in the minds of many, has not the power to enforce social insurance under the guise of a tax." *Id.* at 5466 (Apr. 11, 1935). Representative Treadway, who supported portions of the Act providing support grants to the States, thought that the payroll tax and retirement benefits scheme proposed in Titles II and VIII of the bill was patently unconstitutional. "The Federal Government has no express or inherent power under the Constitution to set up such a scheme," he asserted. 79 Cong. Rec. 5530 (April 12, 1935). And Senator Long, one of the bill's supporters in the Senate, baldly stated:

> Everyone doubts the constitutionality of the bill. Even the proponents of the bill doubt it. . . . I do not believe it is possible for the bill as it is now written to be held constitutional. I would bet everything I have on it. I do not mean that it will be held unconstitutional by a divided court, either. . . . Not a single member of the Supreme Court of the United States will hold this bill constitutional as now written.

79 Cong. Rec. 9531 (June 18, 1935).

Because of these constitutional concerns, proponents of the bill split the retirement provisions into two separate titles—the "tax" provisions of Title VIII, and the benefits provisions of Title II—hoping that this Court would afford some measure of deference to Congress' taxing authority when considering the inevitable constitutional challenge. *See* 79 Cong. Rec. 5530 (Rep. Treadway) ("The reason that these two titles are separated in the bill is that if they were combined, as they should be, they would on their face be unconstitutional, since the Federal Government cannot lay a tax for any other purpose than the raising of revenue for public uses"). Representative Treadway of Massachusetts described this as an attempt by the bill's proponents to "delude" this Court. *Id.*

Congress' efforts were nevertheless upheld. First, Title III of the Social Security Act of 1935, 42 U.S.C. § 501 *et seq.*, was upheld by this Court in 1937 (after external pressure threatened the Court's composition and independence[13]) because it was limited to unemployment benefits, *Steward Mach.*, 301 U.S. at 586-87, and unemployment was "[s]preading from state to state," thus necessitating a national solution, *Helvering v. Davis*, 301 U.S. 619, 641 (1937).

But there was no constitutional analysis in the *Steward* opinion. The Court merely noted that "[i]t is too late today for the argument to be heard with tolerance that in a crisis so extreme [as the Great Depression] the use of the moneys of the nation to relieve the unemployed and their dependents is a use for any purpose narrower than the promotion of the general welfare." 301 U.S. at 586-87. In support of that *ipse dixit*, the Court provided a "cf." citation to *Butler*, 297 U.S. at 65, 66, which just the year before had *struck down* the Agricultural Adjustment Act as beyond the authority of the General Welfare Clause because it did not further a purpose entrusted to the national government.[14] *Butler*, 297 U.S. at 78. How "unemployment" was any more entrusted to the national government than was "agriculture," the *Steward* Court did not say.

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[13] *See, e.g.*, Barry Cushman, *Rethinking the New Deal Court*, 80 Va. L. Rev. 201, 202 n.1 (1994).

[14] The Court also cited *Helvering v. Davis*, 301 U.S. 619, 672 (1937), decided the same day, but *Helvering* itself adds nothing to the analysis, merely stating that the question of the constitutionality of the Social Security Act's retirement provisions was similar to that of the unemployment provisions, already decided in *Steward*. Rarely has there been greater circularity of reasoning in the pages of the *U.S. Reports*.

The same day, in *Helvering*, the Court extended the ruling from unemployment to retirement benefits, again citing *Butler* and, circularly, *Steward*. Here is the full extent of the analysis:

> Spreading from state to state, unemployment is an ill not particular but general, which may be checked, if Congress so determines, by the resources of the nation. . . . But the ill is all one or at least not greatly different whether men are thrown out of work because there is no longer work to do or because the disabilities of age make them incapable of doing it.

Helvering, 301 U.S. at 641. Despite the obvious difference between the two, Title II of the Social Security Act was also upheld.

Thirty years later, Congress entered the health care arena, another realm that had traditionally been viewed as exclusively within the sovereign authority of the States. By then, the view that the General Welfare Clause imposed no limits on Congress had become so pervasive, *Butler* to the contrary notwithstanding, that the 1965 Medicare and Medicaid Amendments to the Social Security Act[15] do not appear to have ever faced a constitutional challenge. If providing both unemployment benefits and old age pensions was permissible because taking care of the needy was in the *general* welfare rather than the concern of the individual states, then providing health care benefits for the poor (Medicaid) and aged (Medicare) must also be permissible, the original rationale that unemployment was "spreading" from one State to another now being forgotten.

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[15] Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 102(a), 121(a), 1965 U.S.C.C.A.N. (79 Stat. 286, 291, 343) 305, 311, 370 (amended 1967) (codified as amended at 42 U.S.C. §§ 1395c to 1395w-4, 1396 to 1396v).

Nevertheless, even the proponents of the 1965 Medicare and Medicaid amendments to the Social Security Act thought it necessary to restrict their efforts to narrowly targeted groups with special health-coverage needs. Medicaid was created only for "the medically indigent, aged, blind, and disabled persons, dependent children and their parents." 111 Cong. Rec. 7369 (1965). Medicare was likewise "*tailored* to meet the needs of our elderly," created in response to the view that existing Social Security benefits were "so low" that many elderly could not afford basic medical care. *Id.* at 7360 (emphasis added); *see also id.* at 7371-72. Congressman Peter Rodino, one of the bill's primary sponsors, rejected efforts for more universal coverage. "Public assistance," he noted, "by its very nature can only benefit the very needy—there must be a requirement that the person demonstrate that he can no longer get along on his own." *Id.* at 7360-61.

Whether the fact that the Medicare and Medicaid programs were originally targeted to particular needy groups would have allowed those programs to withstand a federalism-based constitutional challenge, had one been brought, this Court has subsequently acknowledged that even the Spending Clause has limits. *Dole*, 483 U.S. at 207.

B. Basic Separation of Powers Principles Require This Court to Enforce Constitutional Limits on Spending Authority.

Congress has a solemn duty to exercise power only within the limits of its constitutionally delegated authority. U.S. Const. Art. VI, cl. 3 ("The Senators and Representatives . . . shall be bound by Oath or Affirmation, to support this Constitution"). But, recognizing that power tends not to police itself very well, the Founders designed a constitutional system in which legislative power would be checked by the other branches of government as well. *See, e.g.*, The Federalist No. 51, at 320 (Madison) (C. Rossiter, ed., 1961) (the Constitution was designed so that "its several constituent parts may, by their mutual relations, be the means of keeping each other in their proper places"); *Id.* No. 78, at 467 (Hamilton) ("the courts were designed to be an intermediate body between the people and the legislature in order, among other things, to keep the latter within the limits assigned to their authority").

For more than a half century, presidents performed that check admirably, through an effective use of the veto power. *See, e.g.*, Veto Message of President Madison, 30 Annals of Cong. 211 (1817); Veto Message of President Monroe, 39 Annals of Cong. 1838 (1822); Veto Message of President Jackson, 28 H.R. Journal 29 (1834); Veto Message of President Buchanan 55 H.R. Journal 505-06 (1859). And for another three quarters of a century after that, this Court did as well, invalidating a congressional spending program in *Butler* that did not further powers delegated to the national government. *See generally, e.g.*, John C. Eastman, *Restoring the*

"General" to the General Welfare Clause, 4 Chap. L. Rev. 63 (2001); Robert G. Natelson, *The General Welfare Clause and the Public Trust: An Essay in Original Understanding*, 52 U. Kan. L. Rev. 1 (2003); David E. Engdahl, *The Spending Power*, 44 Duke L.J. 1 (1994). Even when this Court adopted an expansive interpretation of the Spending Clause in *Helvering v. Davis*, it noted that "[t]he line must still be drawn between one welfare and another, between particular and general." 301 U.S. at 640.

Butler demonstrates how the spending power must conform to the overall constitutional design. "*Wholly apart from*" the question "whether an appropriation in aid of agriculture" falls within "the scope of the phrase 'general welfare of the United States,'" the Court held in *Butler* that the Agricultural Adjustment Act was unconstitutional because its purpose was to regulate and control "a matter beyond the powers delegated to the federal government." 297 U.S. at 68 (emphasis added). "[T]he act invades the reserved rights of the states," wrote Justice Roberts for the Court. "The tax, the appropriation of the funds raised, and the direction for their disbursement, are but parts of the plan. They are but means to an unconstitutional end." *Id.* at 68.

Although *Butler* remains valid, it is almost uniformly ignored in the lower courts, encouraged by the lack of a strong commitment in *Dole* to enforcing the constitutional rule that spending must be for "purposes . . . of general, not local, national, not state, benefit." Veto Message of President Monroe, 39 Annals of Cong. 1849; *see Dole*, 483 U.S. at 207 and n.2 (noting that "courts should defer substantially to the judgment of Congress" and questioning "whether 'general welfare' is a judicially enforceable restriction at all").

Yet the "spending power is of course not unlimited." *Dole*, 483 U.S. at 207. The limits are ascertainable, and as this case amply demonstrates, they must be enforced lest the carefully-wrought distinction between what is national and what is local be lost. As Justice Kennedy noted in his opinion concurring in the judgment in *United States v. Comstock*, 130 S.Ct. 1949, 1967 (2010), "[t]he limits upon the spending power have not been much discussed, but if the relevant standard is parallel to the Commerce Clause cases, then the limits and the analytic approach in those precedents should be respected."

The present challenge by the States is not to the constitutionality of the federal spending itself, of course, but rather to the onerous conditions the federal government now seeks to attach to *existing* spending on which the States have come to rely. Nevertheless, both *Butler* and *Dole* recognized that spending must be for a constitutionally-authorized purpose. Whether the massive expansion in spending underlying the States' coercion claim has crossed the line from permissible to impermissible is surely relevant to the subsidiary inquiry whether the States have been unduly coerced into participating.

In sum, Congress is seeking to massively expand its exercise of a police power, the quintessential power reserved to the states and not delegated to the national government. That it is doing so under the strained pretext of its Spending Clause authority does not alter that fact. As the Court's holding in *Butler* confirms, Chief Justice Marshall's admonition in *M'Culloch* v. *Maryland* with respect to the Commerce Clause is equally germane to the spending power: "[S]hould Congress, under the pretext of executing its powers, pass laws for the accomplishment of objects not entrusted to the [national] government; it would become the painful duty of this tribunal . . . to say, that such an act was not the law of the land." 17 U.S. (4 Wheat.) 316, 423 (1819).

CONCLUSION

This Court has previously ratified extensive incursions by the federal government into areas within the States' traditional police powers, incursions that were already pressing the limits of constitutional authority. The ACA is a massive step beyond anything previously undertaken. That it has, through the mechanism of spending conditions, unconstitutionally coerced the States to participate only worsens the constitutional infirmity. If *any* limits on the spending authority of the federal government are to remain, the Medicaid expansion provisions of the ACA must be held unconstitutional.

Respectfully submitted,

EDWIN MEESE III
214 Mass. Ave. NE
Washington, DC 20002

TIMOTHY SANDEFUR
Pacific Legal Foundation
930 G Street
Sacramento, CA 95814

ILYA SHAPIRO
Cato Institute
1000 Mass. Ave., N.W.
Washington, D.C. 20001

JOHN EASTMAN
Counsel of Record
ANTHONY T. CASO
KAREN J. LUGO
Center for Constitutional Jurisprudence
c/o Chapman University School of Law
One University Drive
Orange, CA 92886
(714) 628-2587
jeastman@chapman.edu

Counsel for Amici Curiae

AMICUS
CURIAE
BRIEF

Nos. 11-393 & 11-400

IN THE

Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT
BUSINESS, ET AL., PETITIONERS
v.
KATHLEEN SEBELIUS, ET AL.

STATES OF FLORIDA, ET AL., PETITIONERS
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

On Writ of Certiorari
to the United States Court of Appeals
for the Eleventh Circuit

BRIEF OF CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF REVERSAL AS TO THE SEVERABILITY ISSUE

ROBIN S. CONRAD
SHANE B. KAWKA
KATHRYN COMERFORD TODD
NATIONAL CHAMBER LITIGATION
CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

K. LEE BLALACK II
(*Counsel of Record*)
lblalack@omm.com
BRIAN D. BOYLE
ANTON METLITSKY
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

Attorneys for Amicus Curiae

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BRIEF OF CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF REVERSAL AS TO THE SEVERABILITY ISSUE

This brief is submitted on behalf of the Chamber of Commerce of the United States of America in support of reversal as to the severability issue.[1]

INTEREST OF *AMICUS CURIAE*

The Chamber of Commerce of the United States of America ("the Chamber") is the world's largest business federation, representing the interests of 300,000 direct members and indirectly representing an underlying membership of three million businesses and professional organizations of every size, in every industry sector, and from every region of the country. More than 96 percent of the Chamber's members are small businesses with one hundred or fewer employees. The Chamber advocates on issues of vital concern to the nation's business community and has frequently participated as *amicus curiae* before this Court and other courts. The Chamber participated as *amicus curiae* in support of the Petitions for Certiorari in these cases, as well as in litigation concerning the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("PPACA" or "the

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[1] No counsel for any party has authored this brief in whole or in part, and no person other than *amicus*, its members, or its counsel have made any monetary contribution intended to fund the preparation or submission of this brief. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office.

Act"), in the Courts of Appeals for the Fourth, Eleventh, and District of Columbia Circuits.

Prompt resolution of the fate of the PPACA is of critical importance to Chamber members. Many of the Chamber's members provide health insurance to their employees. More generally, the PPACA imposes a myriad of costly obligations on the business community—as well as on states and consumers. Uncertainty over the future of the PPACA seriously undermines the ability of American businesses to plan for the future, and to make informed decisions concerning investment in growth and hiring. Accordingly, a swift resolution of the constitutionality of the individual mandate, and clarification as to which portions of the PPACA, if any, will survive if the individual mandate falls, are crucial to Chamber members.

INTRODUCTION AND SUMMARY OF ARGUMENT

The PPACA contains an extensive set of reforms primarily intended to make health insurance available to millions of uninsured Americans and to increase the scope of coverage for all Americans. The Act seeks to accomplish this goal in large part through regulation of the market for private health insurance.[2] Although the Act's health insurance reforms are vast in scope and complexity, *see* PPACA, Pub. L. No. 111-148, tit. I, they include several core, interrelated features. First, the Act includes comprehensive reforms of the health insurance industry, regulating the way issuers fund and structure their policies, as well as the form and content of the policies issuers are required to provide. Most prominently, the Act's "guaranteed-issue" provisions require insurance providers to issue health insurance to all comers and prohibit exclusions for preexisting conditions, while the "community-rating" provision requires insurance providers to price premiums based on the health risks of the community, rather than the individual. But the Act also contains a plethora of additional industry regulations, including a prohibition on offering policies in the individual and small-employer markets with less than comprehensive coverage.

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[2] The Act also expands public insurance programs, most notably Medicaid and Medicare. *See* PPACA, Titles II & III.

Second, the Act establishes health insurance Exchanges. The Exchanges are intended to provide centralized information to consumers concerning insurance prices and offerings, and to allow individuals who do not receive coverage through large employers to nevertheless enter a pool of similarly situated individuals, so as to lower the cost of insurance for all participants. The Act establishes federal subsidies, administered through the Exchanges, for whom Congress believed the comprehensive policies issuers will now be required to offer would be too expensive. *See* Appendix to the Petition for a Writ of Certiorari, *U.S. Dep't of Health & Human Servs. v. Florida*, No. 11-398, at 26a-38a ("U.S. Pet. App.").

These and other insurance reforms are highly interdependent and built upon one central provision: the requirement that individuals maintain minimum essential coverage. PPACA § 1501(a) (codified at 26 U.S.C. § 5000A(a)). This so-called "individual mandate" is indispensible to the operation of the health insurance reforms in the Act. Congress understood that simply requiring issuers to provide coverage to all applicants at the same price and under the same terms without regard to their health status would be impractical unless healthy individuals were also required to purchase coverage. Standing alone, these new requirements would lead to less affordable health insurance because significant numbers of healthy individuals would wait to purchase health insurance until they absolutely needed it, forcing issuers to raise premiums for everyone else. Congress included the individual mandate in the PPACA to prevent such strategic consumer behavior, which is often referred to as "adverse selection."

By requiring essentially all individuals to maintain health coverage, Congress sought to prevent the adverse selection that would otherwise undermine the Act's new insurance requirements. Congress also adopted the individual mandate to mitigate the upward pressure on premiums created by other aspects of the law, like the requirement of comprehensive coverage in the individual and small-employer markets or limits the law imposes on enrollee cost-sharing. Through the individual mandate, the law was structured to allow guaranteed-issue, community rating, required minimum coverage levels, the Exchanges, federal subsidies, and other insurance reforms to function in the manner Congress intended. As Congress explained in the Act, the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(a)(2)(I).

The Chamber takes no position on the constitutionality of the individual mandate. If, however, the Court strikes the individual mandate as unconstitutional, determining promptly whether, and to what extent, the remainder of the PPACA will remain in force is of crucial importance to the business community and to the Nation as a whole. Given the scope and complexity of the PPACA, and given that its most far-reaching provisions are imminently scheduled for implementation, the Chamber submits that the most responsible course would be to hold the individual mandate non-severable from the remainder of the Act, in its entirety.

Certainly, the Eleventh Circuit's conclusion that the mandate could be severed from the remainder of the Act is untenable, and will wreak havoc on the health insurance market if left to stand. A proper application of this Court's severability jurisprudence requires a finding that, *at the very least*, the guaranteed-issue and community-rating provisions are non-severable from the individual mandate and must necessarily fall with it.

All of the parties agree that the Eleventh Circuit's severability analysis is fundamentally flawed. For instance, the United States has explained that the Eleventh Circuit's "conclusion that the guaranteed-issue and community-rating provisions could be severed from the minimum coverage provision was incorrect." Consolidated Brief for Respondents at 10, *Nat'l Fed'n of Indep. Bus. v. Sebelius* and *Florida v. Dep't of Health and Human Servs.* (Nos. 11-393 & 11-400) (U.S.). In the absence of the mandate, individuals will have no reason to purchase insurance until they become sick, which will drive up insurance premiums for the remaining consumers. This increase in premiums would in turn cause more healthy individuals to stop purchasing (or refrain from obtaining) health insurance, causing premiums to rise still further. This "premium spiral" has been experienced in various states—such as New York, Kentucky, and Washington—where similar health insurance reforms were enacted without an accompanying individual mandate. The legislative record confirms that Congress understood this market dynamic and the destabilizing effect of guaranteed-issue and community-rating reforms in the absence of an individual mandate.

Contrary to the government's position, however, the health insurance reforms that depend upon the individual mandate extend far beyond the guaranteed-issue and community-rating provisions. The Act's health insurance requirements generally presuppose and depend upon a fully insured (or near-fully insured) populace—achieved through the individual mandate—and a guaranteed-issue regime premised on aggregate (as opposed to individual) pricing. Those fundamental concepts are the foundation for the Act's highly complex and interdependent set of insurance reforms.

For example, the Act requires that health insurers offer comprehensive coverage in the individual and small group markets, and limits the amount of deductibles, co-pays, and other cost-sharing that issuers may require of enrollees. These new requirements will have an obvious—and, according to the Congressional Budget Office, significant—upward impact on premiums. The Act's principal method of mitigating that upward pressure on premiums is through the individual mandate, which requires healthy individuals who currently forego health insurance to purchase it or face a penalty, thus lowering issuers' aggregate risk. Without the individual mandate, then, the Act's other insurance reform provisions would lead to a much higher increase in premiums than Congress anticipated. Further, because the Act's premium subsidies are directly tied to premium levels, in a world without the individual mandate the subsidies would cost taxpayers much more than Congress ever anticipated. And if the subsidies do not work properly, then neither do the Exchanges. And so on. The individual mandate is the proverbial string that, once pulled, causes the remainder of the Act's insurance reforms to unravel.

Thus, contrary to the United States' position, none of the Act's major remaining reforms of the private insurance market will function in the manner Congress intended if the mandate and its closely associated guaranteed-issue and community-rating provisions are invalidated. If the mandate is held unconstitutional, far more than the guaranteed-issue and community-rating provisions must fall with it.

The difficulty presented by legislation as sweeping and complex as the PPACA is determining precisely which additional provisions must fall. As the examples above illustrate, the PPACA's interlocking insurance reforms critically depend on each other to operate properly. But the sheer scope and complexity of the law make it impractical—and, given the inherently legislative choices that would be required, inappropriate—for the Court to determine all of the provisions that must fall if the mandate is invalidated. In other words, while it is easy to demonstrate that the guaranteed-issue and community-rating provisions are non-severable from the mandate, it will be more challenging for the Court to determine precisely how far beyond those provisions the chain of unintended effects extends.

Under different circumstances, the Court might consider a remand for further factfinding by the district court in order to determine with some level of precision whether every other provision of the PPACA would operate as Congress intended in the absence of the mandate. Indeed, the Chamber suggested remand in its brief to the Eleventh Circuit below. But given the expected timing of this Court's decision, and the considerable time it would take for the lower courts to work through the complexities of the analysis that would be required, remand is no longer a viable option. The business community needs certainty regarding the fate of the many costly requirements in the PPACA before businesses can make rational decisions concerning investment in growth and in jobs. A remand for further factfinding, and the ensuing appellate process, would surely run up against—if not past—the Act's 2014 implementation date, which would only prolong the uncertainty, and serve as a further impediment to economic growth.

Given the timetable established by Congress for the implementation of this sprawling legislation, the only appropriate course is to hold the entire Act non-severable from the mandate. This outcome would both avoid the significant market disruptions that would result from invalidating the mandate but leaving the remainder (or parts) of the statute in place, and would give American businesses and consumers much needed clarity on what the law will be going forward. This approach also best respects a proper conception of the separation of powers. Within the bounds of the Constitution, Congress is the institution best suited to craft national policies on the regulation of health insurance markets. With all respect, the Judicial Branch lacks the institutional expertise and capacity to properly analyze the market consequences of excising the core element of a highly complex project to reshape nearly 20% of the national economy. If Congress has surpassed constitutional bounds by enacting the PPACA, then only Congress can decide how to recalibrate its effort to formulate the Nation's healthcare policy without jeopardizing the very market for health insurance that the Act seeks to expand.

ARGUMENT

I. THE PPACA INSTITUTES A MASSIVE AND HIGHLY COMPLEX REORGANIZATION OF THE MARKET FOR PRIVATE HEALTH INSURANCE

The PPACA is one of the most significant and complicated congressional enactments in decades. It "comprehensively reform[s] and regulate[s] more than one-sixth of the national economy," "via several hundred statutory provisions and thousands of regulations that put myriad obligations and responsibilities on individuals, employers, and the states." U.S. Pet. App. 391a. Indeed, "the Act's nine Titles contain hundreds of new laws about hundreds of different areas of health insurance and health care." U.S. Pet. App. 21a.

Nevertheless, the heart of the Act's "comprehensive and complex regulatory scheme," U.S. Pet. App. 22a, is indisputably the reform of the private market for health insurance. *E.g.*, U.S. Pet. App. 356a-358a. Indeed, the Act states that it seeks to achieve "near-universal coverage by building upon and strengthening the private employer-based health insurance system." 42 U.S.C. § 18091(a)(2)(D). The Act's health insurance reforms, principally found in Title I, fall into several discrete, though interrelated, categories, as explained below.

A. Health Insurance Industry Reforms

In an attempt to "reduce the number of the uninsured, the Act heavily regulates private insurers and reforms their health insurance products." U.S. Pet. App. 26a.

1. *Guaranteed-Issue and Community Rating*

Some of the most prominent health insurance industry reforms involve a shift away from traditional medical underwriting—by which issuers evaluate risk, and decide whether and on what terms to indemnify against medical costs, on an individual basis—to a system where issuers *must* offer policies to all comers, and *must* price those policies on the basis of community (rather than individual) risk.

In particular, the PPACA's guaranteed-issue provisions require issuers to accept every applicant for health insurance coverage, and bar issuers from denying coverage based on preexisting conditions or medical history. *See, e.g.*, 42 U.S.C. §§ 300gg-1(a), 300gg-4(a). The PPACA's community-rating provision prescribes that issuers may not charge higher premiums based on preexisting conditions and certain other factors, and also states that (except for age, geography, and tobacco use) premiums must be based on the actuarial risk of a community "rating area," rather than the individual. *See* 42 U.S.C. § 300gg(a)(1). Therefore, those provisions limit the traditional underwriting factors issuers may consider in pricing and offering coverage.

2. *Other Health Insurance Industry Reforms*

The PPACA also includes a vast array of other reforms that go to the core of how the health insurance industry structures and operates its business. There is no need here for an exhaustive list, but several examples help illustrate the thrust of the reforms: Insurers that offer coverage to individuals and small groups are required to provide a so-called "essential health benefits package," 42 U.S.C. § 300gg-6(a), a "comprehensive coverage" package (U.S. Pet. App. 29a) the contents of which are prescribed by statute and regulation, 42 U.S.C. § 18022. These policies must have guaranteed renewability, *id.* § 300gg-2, and can be rescinded only under very limited circumstances, *id.* § 300gg-12. The Act places limits on cost-sharing by enrollees (such as deductibles and copays) for many health plans, *id.* §§ 300gg-6(b), 18022(a), (c), and precludes health plans from having lifetime or annual limits on essential health benefits, *id.* § 300gg-11(a). Issuers must also maintain certain specified ratios of revenue dollars spent on medical care versus administrative and other overhead expenses. *Id.* § 300gg-18 (medical loss ratio).

B. Exchanges and Federal Subsidies

By January 1, 2014, each state must establish health-insurance Exchanges, "which are insurance marketplaces where individuals, families, and small employers can shop for the Act's new insurance products." U.S. Pet. App. 32a (citing 42 U.S.C. § 18031(b)). The Exchanges are meant to create "new marketplaces through which individuals, families, and small employers ... can competitively purchase the new insurance products" that insurers must offer. U.S. Pet. App. 15a. With limited exceptions, the plans sold in the Exchanges must cover the "essential health benefits package." 42 U.S.C. § 18021(a)(1)(B).

The PPACA further establishes significant subsidies (in the form of tax credits) designed to aid certain individuals to purchase insurance through the Exchanges. In particular, the Act establishes a subsidy for those individuals with household incomes between 1 and 4 times the federal poverty limit who purchase health insurance through an Exchange. 26 U.S.C. § 36B. The amount of the subsidy is determined by the premium amount within the enrollee's rating area, for a specified variant of the "essential health benefits package." *Id.* § 36B(b).

C. Individual Mandate

The individual mandate is a "central pillar" of the PPACA.[3] The mandate requires that all individuals—with certain limited exceptions, most notably for individuals who cannot afford coverage, 26 U.S.C. § 5000A(e)—obtain and maintain "minimum essential coverage," either on the individual market or through the individual's employer. *Id.* § 5000A.[4]

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[3] Jonathan Gruber, *Health Care Reform Without the Individual Mandate*, Center for American Progress (Feb. 9, 2011), http://www.americanprogress.org/issues/2011/02/gruber_mandate.html.

Congress intended for the mandate to further three separate but related objectives. First, and most generally, the mandate is one of Act's main tools to achieve near-universal coverage. The mandate, "together with the other provisions of th[e] Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured." 42 U.S.C. § 18091(a)(2)(C). The mandate will help "achieve[] near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide." *Id.* § 18091(a)(2)(D).

Second, the mandate is intended to help lower premiums—and to counteract premium increases caused by other requirements in the Act—by increasing the pool of insureds, particularly healthy individuals. *See id.* § 18091(a)(2)(F). The mandate helps restrain premium increases in large part because it "essentially requires low-risk individuals to cross-subsidize high-risk individuals." Amy B. Monahan,

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[4] The Act also requires larger employers to provide their employees the option to purchase comprehensive health insurance, or else to pay a penalty. 26 U.S.C. § 4980H. The penalty is assessed if at least one of the employer's employees participates in an Exchange and is eligible for a tax credit or subsidy under the Act. *Id.* § 4980H(a).

On Subsidies and Mandates: A Regulatory Critique of ACA, 36 J. Corp. L. 781, 787 (2011).

Third, and maybe most important, the mandate serves to remove the incentives for adverse selection that are created by other provisions of the Act, most notably the guaranteed-issue and community-rating requirements. With guaranteed-issue and community rating, but no coverage mandate, "many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the [mandate], together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." 42 U.S.C. § 18091(a)(2)(I).

Thus, in the Act, Congress stated clearly that the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.* Indeed, as demonstrated more fully below, the individual mandate is the glue that holds the remainder of the PPACA's insurance reforms together. Without the mandate, the reforms of the health insurance market in Title I, which are the heart of the entire Act, cannot operate in the manner Congress intended. For the reasons explained below, if the mandate is held unconstitutional, then the PPACA should be invalidated in its entirety.

II. THE INDIVIDUAL MANDATE IS NON-SEVERABLE FROM THE REMAINDER OF THE PPACA

This Court has explained that when a particular statutory provision is stricken on the ground that it exceeds Congress's constitutional powers, and Congress has not declared its intentions in a severability clause, the remaining provisions must also fall if "it is evident that the Legislature would not have enacted those provisions ... independently of that which is [invalid]." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quotation omitted; omission and alteration in original). In other words, the question is whether Congress would have enacted the remaining provisions in the absence of the invalid one. *See Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) ("[T]he unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted."). That overarching question turns on an assessment of whether the remaining provisions "will function in a *manner* consistent with the intent of Congress" in the absence of the invalidated provision. *Id.* (emphasis in original).

In the ordinary case where, as here, Congress has not provided direction in a severability clause, there is a presumption in favor of severability. This presumption rests on the logic that leaving as much of a statute in place as possible will be most faithful to congressional intent and separation-of-powers principles. But the PPACA is no ordinary statute. Excising the individual mandate from the remainder of the Act would undermine the intended operation of the health insurance reforms in Title I of the Act.

Indeed, the sheer complexity and interlocking nature of the reforms Congress adopted make it virtually impossible to trace all of the market-dislocating impacts of excising the mandate. Any mistake in drawing these lines could lead to significant distortions of a market that represents almost one-fifth of the U.S. economy. Because such a perilous effort is far outside the judicial ken, separation-of-powers principles counsel in favor of returning these difficult judgments to Congress. In sum, if the mandate is excised from the Act, then the remainder of the Act also must fall.

A. The United States Concedes That The PPACA's Guaranteed-Issue And Community-Rating Provisions Are Non-Severable From The Individual Mandate

A proper application of the severability principles described above demonstrates that the court of appeals erred in holding the individual mandate severable from the PPACA's guaranteed-issue and community-rating provisions.

1. The PPACA's guaranteed-issue provisions require that insurance providers issue health insurance to all comers, and that they do not reject any applicants based on preexisting conditions. The community-rating provision requires that insurers issuing policies to individuals and employees of small employers assess risk for purposes of premium calculation based on the aggregate risk of large, predetermined "rating areas," rather than on the basis of the applicant's risk profile. *See supra* Part I.A.1.

Those provisions would not remotely "function in a *manner* consistent with the intent of Congress" without the individual mandate. *Alaska Airlines*, 480 U.S. at 685. Without the individual mandate, the guaranteed-issue and community-rating provisions would produce rampant adverse selection, because a significant percentage of currently healthy individuals would defer purchasing health insurance until they became ill, leading to a sharp increase in premiums for consumers choosing to maintain health coverage voluntarily. It is thus no surprise that the United States has conceded, as it must, that the PPACA's guaranteed-issue and community-rating provisions cannot survive without the individual mandate. *See, e.g.*, Consolidated Brief for Respondents at 10 ("[T]he [Eleventh Circuit's] conclusion that the guaranteed-issue and community-rating provisions could be severed from the minimum coverage provision was incorrect.").

Congress fully recognized the interrelationship between those reforms and the mandate in the express terms of the Act:

> [I]f there were no [coverage] requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products

> that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

42 U.S.C. § 18091(a)(2)(I). As the United States has starkly explained, "'[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance, tends to lead to a death spiral of individual insurance.'" Consolidated Brief for Respondents at 32 (quoting Uwe E. Reinhardt, *Prepared Statement for Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce*, 111th Cong. 11 (Mar. 17, 2009)[5]). In light of Congress's own statement of its intent, the guaranteed-issue and community-rating provisions are plainly non-severable from the individual mandate.[6]

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[5] *Available at* http://democrats.energycommerce.house.gov/Press_111/20090317/testimony_reinhardt.pdf.

[6] Experts in the health care field share the view that the individual mandate is essential to the intended operation of the PPACA's guaranteed-issue and community-rating provisions. *See, e.g.*, Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the PPACA*, 364 New Eng. J. Med. 16e (Mar. 10, 2011) ("Although they are politically popular, these community-rating and guaranteed-issue provisions can reduce the stability of private health insurance markets.... The primary purpose of the individual mandate is to mitigate this adverse selection...."); Anthony T. Lasso, *Community Rating and Guaranteed Issue in the Individual Health Insurance Market*, National Institute for Health Care Management Foundation, at 2 (Jan. 2011), *available at* http://nihcm.org/pdf/EV-LoSassoFINAL.pdf (stressing the "distortions that can result from community rating and guaranteed issue regulations in the non-group market when there are no

Congress's concern about an implosion of health insurance markets is further reinforced by the actual experience of various states that have implemented comparable community-rating and guaranteed-issue provisions without an individual mandate. Seven states have enacted guaranteed-issue laws without an accompanying mandate. Ky. Rev. Stat. Ann. § 304.17A-060(2)(A) (1994) (repealed 1998); Me. Rev. Stat. tit. 24-A, § 2736-C(3); N.H. Rev. Stat. § 420-G:6; N.J. Stat. § 17B:27A-22; N.Y. Ins. L. §§ 3231, 3232; Vt. Stat. Ann. tit. 8, § 4080B(d)(1); Wash. Code § 48.43.012(1). Studies in those states reveal precisely the type of adverse selection that Congress sought to avoid in the PPACA. *See* Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol., Pol'y & L. 71, 97 (2000) ("Following reform, the overall percentage of the population with insurance has worsened...."); Roberta B. Meyer, *Justification for Permitting Life Insurers to Continue to Underwrite on the Basis of Genetic Information and Genetic Test Results*, 27 Suffolk U. L. Rev. 1271, 1291 (1993) (New York's community-rating requirement "has led to an increase in rates for young, healthy insureds" and "many of them have dropped their health insurance coverage"). Indeed, the Kentucky Legislature repealed its market reforms because they destabilized the health insurance market. *Cf.*

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provisions in place to keep people enrolled in coverage"); Jonathan Gruber, *Why We Need the Individual Mandate: Without a Mandate, Health Reform Would Cover Fewer With Higher Premiums*, Center for American Progress, at 1 (Apr. 8, 2010), *available at* http://www.americanprogress.org/issues/2010/04/pdf/individual_mandate.pdf ("Without the individual mandate, the entire structure of reform would fail.").

Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts*, 25 J. Health Pol., Pol'y & L. 133, 151 (2000) ("The Kentucky reform experience has become notorious for the mass exit of insurers from its market.").

There is no basis in logic or experience to doubt Congress's express understanding that the individual mandate is "essential" to the proper functioning of a health insurance market that includes the PPACA's guaranteed-issue and community-rating provisions. 42 U.S.C. § 18091(a)(2)(I). The individual mandate and those reforms are tightly interwoven and must therefore stand or fall together. *Cf. Carter v. Carter Coal Co.*, 298 U.S. 238, 315-16 (1936) ("These two sets of requirements are not like a collection of bricks, some of which may be taken away without disturbing the others, but rather are like the interwoven threads constituting the warp and woof of a fabric, one set of which cannot be removed without fatal consequences to the whole.").

2. The Eleventh Circuit's holding to the contrary seriously misunderstands the PPACA, and this Court's severability jurisprudence. The Eleventh Circuit held the individual mandate severable from the guaranteed-issue and community-rating provisions because the mandate that Congress enacted would, in the court's view, not be sufficiently effective in achieving its goal of combating adverse selection, and Congress thus would have enacted the guaranteed-issue and community-rating provisions without it. U.S. Pet. App. 179a-186a.

The Eleventh Circuit's analysis of the effectiveness of the mandate is contradicted by the expert analysis cited above, the repeated experience of states who saw premiums rise drastically without an individual mandate, and the position of the United States. But even assuming the court's estimation of the mandate's effectiveness were correct, the court's severability analysis is nevertheless flawed because it asks the wrong question. This Court's severability jurisprudence does not call on courts to engage in the quintessentially legislative function of deciding how effective a particular congressional enactment will be in achieving its stated goal. Rather, the ultimate question, as explained, is whether the guaranteed-issue and community-rating provisions "will function in a *manner* consistent with the intent of Congress" in the absence of the individual mandate. *Alaska Airlines*, 480 U.S. at 685.

Here, Congress itself provided the answer to that question. Again, Congress explained that the mandate is "essential" to the guaranteed-issue and community-rating reforms. 42 U.S.C. § 18091(a)(2)(I). What is more, Congress explained why: "if there were no [mandate], many individuals would wait to purchase health insurance until they needed care," thus leading to a rise in premiums. *Id.* The Eleventh Circuit's own judgment to the contrary cannot trump Congress's express finding.

Further, Congress was fully aware of the failed attempts by various states to enact a guaranteed-issue and community-rated insurance regime without an individual mandate, and had testimony prominently before it that guaranteed-issue and community rating in the absence of a mandate will lead to adverse selection and sharply increased premiums. *See supra* at 18-20. Indeed, if Congress could have enacted guaranteed-issue and community-rating reforms that would function as intended without the highly controversial individual mandate, it surely would have done so.

In sum, Congress enacted the individual mandate because it believed that it was "essential" to counteracting the adverse selection costs of the guaranteed-issue and community-rating reforms. Whether those reforms could, in some sense, operate independently of the mandate—as the Eleventh Circuit believes they could—there is no plausible argument that they would "function in a *manner* consistent with the intent of Congress" in the absence of the individual mandate. *Alaska Airlines*, 480 U.S. at 685.

Accordingly, as the United States concedes, the PPACA's guaranteed-issue and community-rating provisions are non-severable from the individual mandate. As demonstrated below, however, the mandate is "essential" to much more of the Act than the guaranteed-issue and community-rating reforms.

B. All Of The Health Insurance Reforms In Title I Of The Act Depend, Either Directly Or Indirectly, On The Individual Mandate

Although the United States has agreed that the guaranteed-issue and community-rating provisions of the Act cannot stand without the individual mandate, it has (at least thus far) argued that the remainder of the PPACA can remain intact, as enacted. That position is wholly untenable. The Act's central innovation—a massive reordering of the market for private health insurance—is anchored on the existence of the near-fully insured market that would be created by the mandate, and on its associated guaranteed-issue and community-rating requirements. Absent those key interdependent provisions, none of the PPACA's other reforms of the private insurance market will operate as Congress intended.

1. *Insurance industry reforms beyond guaranteed-issue and community rating*

The individual mandate and its associated guaranteed-issue and community-rating provisions are tied directly to the PPACA's industry reform provisions generally, and to particular provisions more specifically.

(a) Health insurance industry reforms generally

As explained above, the PPACA imposes a vast array of new requirements on how private issuers are to operate, and the structure of the plans they must offer. *See supra* Part I.A. Those insurance market reforms are built upon the foundation of the individual mandate. For example, with very few exceptions, insurers will be required to offer in the individual and small-employer markets only policies that include a comprehensive benefits package—the so-called "essential health benefits package." 42 U.S.C. §§ 300gg-6(a), 18022. The Act also (among many other things) requires guaranteed renewability, imposes sharp restrictions on the circumstances under which policies can be rescinded, imposes limits on cost-sharing by enrollees, precludes lifetime or annual limits on "essential health benefits," and requires issuers to maintain high ratios of dollars spent on medical care as compared to administrative costs. *See supra* Part I.A.2.

These provisions, among other things, will force an increase in the actuarial value of every plan, and will (without countervailing requirements) lead inexorably to sharp increases in premiums. Indeed, the Congressional Budget Office found that—independent of the guaranteed-issue and community-rating provisions—the expansion of benefits, reduction in cost-sharing, and other industry reforms would alone lead to premium increases in the individual and small-employer markets of *27 to 30 percent.*[7]

The individual mandate is the principal tool (along with the Exchanges and subsidies) that Congress chose to mitigate the dramatic increase in premiums that will result from the required expansion of benefits and decrease in cost-sharing by enrollees. The mandate "essentially requires low-risk individuals to cross-subsidize high-risk individuals," Monahan, *supra*, at 787, thus putting downward pressure on premiums. *See also* 42 U.S.C.

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[7] CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6 (Nov. 30, 2009) ("CBO, *Premiums*"), available at http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf. This increase in premiums assumes the existence of the individual mandate, but the 27-30% figure does not include the mandate's mitigating effect on premiums, which are calculated separately. Thus, the 27-30% figure does *not* include any premium increases that would result from adverse selection prompted by guaranteed-issue and community-rating requirements in the absence of a mandate.

§ 18091(a)(2)(F) ("By significantly reducing the number of the uninsured, the [mandate], together with the other provisions of this Act, will lower health insurance premiums."); CBO, *Premiums*, at 6. Thus, without the individual mandate's mitigating effects on premiums, the health insurance regulations in the Act would not operate even remotely in the manner Congress intended.[8]

Moreover, beyond the general, sharp increase in premiums that would result from affirming the Eleventh Circuit's severability analysis, the mandate and/or the guaranteed-issue and community-rating provisions are specifically tied to several of the insurance market reforms, as shown directly below.

(b) The risk-adjustment provision

The PPACA's risk-adjustment provision, 42 U.S.C. § 18063, would not function as Congress intended without the individual mandate and its associated guaranteed-issue and community-rating provisions. Under a community-rating system, health plans generally obtain the same premium per subscriber, regardless of a subscriber's health status, gender, or other demographic factors. Issuers with healthier subscribers may receive a windfall because they earn an identical premium (per subscriber) to plans that must pay more in claims. *See* Robert Kuttner, *The Risk-Adjustment Debate*, 339 New Eng. J. Med. 1952, 1952 (Dec. 24, 1998) ("If plans receive the same unadjusted premium for each subscriber, then the plan with healthier members reaps an unearned windfall."). This type of regulatory system often creates incentives for so-called "cream skimming," i.e., efforts to attract healthier subscribers and discourage riskier individuals, instead of rewarding the provision of quality service. *Id.*

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[8] The subsidies provided in the Act would also be much more expensive than Congress expected, since they are directly tied to premiums. *See infra* at 32-33.

The PPACA's risk-adjustment provision counteracts those incentives by reallocating premiums in a manner proportional to the actuarial risk of each health insurer's subscribers. Under the risk-adjustment provision, states must levy a charge on insurers whose level of actuarial risk falls below the statewide average. 42 U.S.C. § 18063. States then transfer those funds to issuers carrying an actuarial risk exceeding the statewide average. By aligning premium revenues with actuarial risk, the risk-adjustment mechanism diminishes the incentive to target healthier populations. *See* General Accounting Office, *Health Care Reform: Considerations for Risk Adjustment under Community Rating*, GAO/HEHS 94-173, at 1 (Sept. 22, 1994), *available at* http://archive.gao.gov/t2pbat2/152795.pdf (risk adjustment is meant to "reduce the undesirable effects of community rating on insurers' incentives").

If the individual mandate and the associated community-rating reforms were invalidated, the risk-adjustment provision would not function as Congress intended. Without community rating, health insurers would apply traditional underwriting principles, varying premium rates based on health risk and other relevant factors. In such market conditions, an issuer's premiums should already reflect the actuarial risk of its subscribers. Thus, imposing a risk-adjustment mechanism in a market which permits traditional medical underwriting would perversely transfer premium dollars from issuers who accurately assessed the actuarial risk of their subscribers to other issuers who misjudged their risk pools. In fact, it would create a disincentive for issuers to make appropriate investments in underwriting capacity, and instead choose to rely on the risk-adjustment mechanism to recoup any losses they may have sustained. That, in turn, would create gross inefficiencies unintended by Congress and it would be contrary to one of the central aims of the PPACA: promoting affordable health care.

(c) The bar on annual limits for benefits

The PPACA severely restricts, and upon the effective date of the mandate prohibits, issuers from imposing annual limits on the benefits paid to subscribers. 42 U.S.C. § 300gg-11. These restrictions currently dictate that annual limits may not be less than $750,000 per person. Interim Final Rule, 75 Fed. Reg. 37,188, 37,191 (June 28, 2010). That floor increases to $1.25 million per person in September, 2011, to $2 million per person in September, 2012, and plans with annual limits will be phased out entirely by 2014, when the individual mandate becomes effective. *Id.*[9] This new provision will eliminate plans with low annual limits, including so called "mini-med" or "limited benefit" plans, often the most affordable plans for individuals with limited income.[10]

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[9] Section 300gg-11 imposes similar restrictions on lifetime limits on the benefits to be paid to subscribers, which are tied to the individual mandate for the same reasons as the annual limits.

This prohibition against annual limits only functions as intended when considered alongside the individual mandate and guaranteed-issue reforms. As previously noted, a primary purpose of the individual mandate is to avoid the potential spiral of continually deteriorating risk pools and escalating premiums. Congress understood that the mandate was critical to minimizing "adverse selection and broaden[ing] the health insurance risk pool to include healthy individuals ... [in order to] lower health insurance premiums." 42 U.S.C. § 18091(a)(2)(I). But if the bar on annual limits were enforced in the absence of the individual mandate and guaranteed-issue reforms, it would eliminate one of the most affordable health insurance options for lower income individuals and thereby expand the pool of uninsured individuals contrary to Congress's intent.

While the implementation of the PPACA's restrictions on low annual limits has already commenced, the Secretary of HHS has liberally granted waivers to enable low-cost plans to continue operating until the mandate and guaranteed-issue provisions become effective in 2014. *See Health Care Issues Involving the Center for Consumer Information and Insurance Oversight: Hearing of the Oversight & Investigations Subcomm. of the H. Energy & Commerce Comm.* 111th Cong. (Feb. 16, 2011) (statement of Steven Larsen, Director, Ctr. for Consumer Info.

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[10] *See, e.g.*, David R. Henderson, *Mini-Med Plans*, Nat'l Ctr. for Policy Analysis, (Oct. 21, 2010), *available at*, http://www.ncpa.org/pdfs/ba727.pdf.

& Ins. Oversight, Ctrs. for Medicare & Medicaid Servs.) ("[I]n establishing the waiver process ... we did want to make sure that people who have that coverage ... can continue that coverage"). As of June 2011, the Secretary has granted nearly 1500 waivers to plans with annual limits below the current $750,000 threshold, exempting them from the Act's annual limit requirements.[11] The Secretary's granting of waivers to these plans demonstrates that the regulation of annual limits cannot function as intended without the individual mandate and guaranteed-issue reforms.

(d) Medical loss ratio regulation

The PPACA's Medical Loss Ratio ("MLR") requirement, 42 U.S.C. § 300gg-18, is another example of a provision that is inextricably linked to the individual mandate. "Medical Loss Ratio" refers to the percentage of each premium dollar expended by an issuer on the provision of health care to its subscribers and certain quality improvement measures, as opposed to other expenses such as administrative costs, salaries, advertising, and profits. The PPACA establishes a minimum MLR of 80 percent for individual and small group coverage, and 85 percent for large group coverage. *Id.* § 300gg-18.

Congress predicated the MLR provision on the reduction in medical underwriting and other administrative costs that would accompany the individual mandate and guaranteed-issue reforms. *Id.*

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[11] *See* Marli D. Riggs, *More PPACA Waivers Granted; Tally Increases to 1,471*, Employment Benefit Adviser (July 19, 2011), *available at* http://eba.benefitnews.com/news/health-care-obama-waivers-ppaca-hhs-2715651-1.html.

§ 18091(a)(2)(J) ("By significantly increasing health insurance coverage and the size of purchasing pools ... [PPACA] will significantly reduce administrative costs and lower health insurance premiums."). Conversely, absent the mandate's expanded risk pool and its associated community-rating provisions (provisions which have the effect of reducing underwriting costs), administrative costs will necessarily be higher. *See id.* (pre-PPACA, "[a]dministrative costs for private health insurance ... are 26 to 30 percent of premiums in the current individual and small group markets," an amount greater than the administrative costs contemplated under applicable MLR caps). The MLR provision effectively assumes the existence of a market without medical underwriting.[12]

It is therefore no surprise that seventeen states have requested exemptions from the individual-market MLR requirements in the PPACA until the individual mandate takes effect.[13] And the Secretary has thus far granted such an exemption, in whole or in part, to Georgia, Iowa, Kentucky, Maine, New Hampshire, and Nevada, while five states' applications remain pending.[14] For instance, the Secretary granted Maine an exemption from the Act's MLR requirements, adjusting Maine's individual health insurance market MLR rate to sixty-five percent through 2013. Letter from Steven B. Larsen to Mila Kofman, Me. Superintendent of Ins. (Mar. 8, 2011).[15] The ruling that granted Maine's waiver request explicitly noted that "there is a reasonable likelihood" that issuers "would exit the Maine individual market in the absence of an adjustment to the 80 percent MLR standard." *Id.* at 16. These waivers, along with those that are sure to be granted in the near future, are compelling evidence that the long-term operation of the Act's MLR provision is predicated on the individual mandate and community-rating provisions, and cannot function as intended without those provisions.

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[12] To be sure, the Exchanges are likewise intended to lower administrative costs. As explained below, however, the Exchanges will not operate properly if the mandate and its associated guaranteed-issue and community-rating provisions are invalidated as all the parties urge. *See infra* at 31-33.

[13] *See* Dep't of Health and Human Servs., *Medical Loss Ratio*, *available at* http://cciio.cms.gov/programs/marketreforms/mlr/index.html ("HHS, MLR Website").

These examples are illustrative, not exhaustive. They serve to demonstrate only that the individual mandate is indispensable to a vast array of the Act's insurance market reforms, not just the guaranteed-issue and community-rating reforms.

2. *Exchanges and subsidies*

The mandate's reach goes far beyond the PPACA's insurance industry reforms. Invalidation of the individual mandate and/or its associated guaranteed-issue and community-rating provisions would also undermine the intended operation of the other major aspect of private insurance reform: the Act's Exchanges, and the federal subsidies available to certain individuals who obtain coverage in the Exchanges.

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[14] *See* HHS, MLR Website. The Secretary denied the applications of Delaware, Indiana, Florida, Louisiana, Michigan, and North Dakota. *Id.*

[15] *Available at* http://cciio.cms.gov/programs/marketreforms/mlr/states/maine/maine_decision_letter_3_8_11.pdf.

(a) Exchanges

The Exchanges would not function as Congress intended without community rating. The Exchanges are meant to allow consumers to "compare prices and buy coverage from one of the Exchange's issuers" at reduced cost. U.S. Pet. App. 32a-33a. But with traditional medical underwriting, where each policy's level of benefits and premiums is based on individual risk, the Exchanges would not decrease administrative costs to the extent Congress envisioned. Indeed, PPACA's Exchange provisions expressly assume a community-rating regime: each Exchange must be "at least as large as a rating area" used to calculate community-rated premiums. 42 U.S.C. § 18031(f)(2).

(b) Subsidies

Further, excising the individual mandate and/or its associated guaranteed-issue and community-rating provisions will undermine the Exchanges by interfering with the operation of one of the Exchanges' central foundations: federal subsidies to help individuals purchase insurance through the Exchanges. The subsidies cannot operate as intended without the individual mandate and its associated provisions for several reasons.

Most obviously, the tax-credit subsidies are directly tied to a community-rating regime, and to the "essential health benefits" requirement. The subsidy due to any individual is calculated based on the premiums charged for the "second lowest cost silver plan"—i.e., a plan that offers "essential health benefits," 42 U.S.C. § 18022(d)—within the individual's "rating area." 26 U.S.C. § 36B(b). The statutory provision establishing the subsidies is thus literally senseless without community rating or the "essential health benefits" requirement.

The subsidies could technically be administered without the mandate, of course, if the community-rating provision and the "essential health benefits" requirement were preserved. But all parties agree that community rating cannot survive without the mandate, and as explained above, retaining either community rating, or the "essential health benefits" requirement, or both, without the countervailing effect of a mandate would put sharp upward pressure on premiums in a manner contrary to congressional intent. And because the size of the subsidies is tied to premiums within a rating area, a sharp rise in those premiums would entail a sharp rise in subsidies. Further, an increase in premiums will inevitably lead even more people into the Exchanges, and in particular will lead more people to seek subsidies. Thus, the cost of those subsidies to taxpayers would be far higher than Congress ever intended, and the subsidies would thus not "function in a manner consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted).

C. If The Mandate Is Held Unconstitutional, The Appropriate Remedy, Consistent With The Separation Of Powers, Is To Invalidate The PPACA In Its Entirety

As the above discussion demonstrates, invalidation of the individual mandate will cause many of the Act's insurance reforms—beyond guaranteed-issue and community rating—to function in a manner different than Congress intended. While space constraints make it impossible for the Chamber to detail the full extent to which striking only the mandate will destabilize the health insurance markets regulated by the Act, the examples discussed above illustrate the interdependent nature of the PPACA's many complex provisions. The Chamber submits that pulling this one thread—the individual mandate—must unravel many other provisions of the Act.

The question, then, is the proper approach to determine which portions of the PPACA, beyond those described above, must be invalidated if the individual mandate is held unconstitutional. One possible approach would be to hold each of the provisions discussed in the preceding section non-severable, and to remand the remaining portions of the Act for a detailed factual determination about the precise effect of the stricken provisions on each of the PPACA's remaining provisions.

But that approach is no longer practical, for several reasons. First, Congress has directed that most provisions of the Act take effect less than two years from the filing of this brief. This Court's decision concerning the constitutionality of the mandate will not likely be issued until late June 2012. And if there were a remand, the severability question would not be decided at the district court level for many more months, with final resolution (including exhaustion of appeals) likely occurring years from now. In the meantime, as the Chamber explained in its certiorari-stage amicus brief (at 7-10), the uncertainty over which provisions of the PPACA will remain continues to act as an enormous drag on American businesses and the economy. Swift resolution of the severability question is critically important, and this Court should therefore provide a definitive answer now, without the necessity for remand.

Second, while the severability analysis as to some provisions—like guaranteed-issue and community rating—is easy, determining how the loss of the mandate would affect hundreds of other provisions of the PPACA is an unprecedented task ill-suited to the judiciary, given the Act's complexity and interlocking nature, and given the large portion of the economy it seeks to regulate. Attempting to decipher how the market for health insurance will respond when one "essential" thread is pulled, in a statute this complicated and this vast, is a task that Congress is institutionally much better situated to undertake. As shown above, and contrary to the government's past positions, the functional importance of the mandate extends far beyond the guaranteed-issue and community-rating provisions, but the complex and interrelated nature of the PPACA's many provisions makes the task of determining which provisions *can* operate as intended without the mandate exceedingly difficult for a court. The mandate *at least* is essential to the operation of the private insurance reforms in Title I of the Act, but there can be no doubt that invalidating the mandate will also affect the remainder of the Act's operation, and its overarching purpose of expanding coverage to nearly all Americans.[16] And even if the effects of the mandate could definitively be said to stop at Title I, the PPACA without the insurance reforms in Title I is simply a different statute—there is no plausible basis to believe that Congress would have enacted the remainder of the statute without those reforms.

Any judicial attempt to decide just how far the individual mandate's effects reach, but no further, is especially treacherous because the stakes are so high—a wrong decision could seriously distort a market reflecting nearly 20% of the Nation's economy. Accordingly, the appropriate and practical option that will avoid potentially serious consequences for the healthcare and health insurance markets is to strike down the PPACA in toto, and allow Congress to decide how best to balance its policy preferences in a manner consistent with the Constitution.

Furthermore, the invalidation of the PPACA as a whole best comports with the separation of powers. This Court has in some cases stated that, because of separation-of-powers concerns and deference to Congress, "the 'normal rule' is that 'that partial, rather than facial, invalidation is the required course.'" *Free Enter. Fund*, 130 S. Ct. at 3161 (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985)). This, however, is far from a "normal" case, and the PPACA is certainly not a "normal" statute. To begin, the individual mandate is not, as in *Alaska Airlines*, an "uncontroversial" provision of "relative unimportance" to the PPACA. 480 U.S. at 694 n.18, 696. On the contrary, Congress itself explained that the mandate is "*essential* to creating effective health insurance markets," 42 U.S.C. § 18091(a)(2)(I) (emphasis added), which is one of the PPACA's central objectives.

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[16] *See, e.g.*, CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf ("Under current law, CBO and JCT have estimated that about 23 million nonelderly residents will be uninsured in 2019. By eliminating the individual mandate to obtain coverage, the proposal would increase the number of uninsured by about 16 million people, resulting in an estimated 39 million uninsured in 2019.").

More important, the PPACA's sheer complexity, the interdependence of its provisions, and its immense regulatory reach render it unlike any statute at issue in the Court's modern severability jurisprudence. Unlike, for example, certain challenged provisions of the Airline Deregulation Act, *see Alaska Airlines*, 480 U.S. at 680, a portion of Sarbanes-Oxley creating an accounting oversight board, *Free Enter. Fund*, 130 S. Ct. at 3147, or a statute regulating the disposal of nuclear waste, *New York v. United States*, 505 U.S. 144, 149 (1992), the PPACA comprehensively restructures nearly 20% of the Nation's economy. It does so through "hundreds of new laws about hundreds of different areas of health insurance and health care." U.S. Pet. App. 21a. And those laws—particularly the ones governing the market for private insurance—do not (and are not intended to) operate independently. On the contrary, as described above, the PPACA's various regulations of health insurance are complex, intertwined, and interdependent. Retaining any portion of the Act without the mandate would not be saving Congress's work, but rather rewriting it. And courts "are not free to rewrite the statute that Congress has enacted." *Dodd v. United States*, 545 U.S. 353, 359 (2005).

Accordingly, to the extent there is any "presumption ... in favor of severability" generally, *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984) (plurality opinion), that presumption should easily be overcome in the unique circumstances here. Judicial restraint and a candid recognition of the institutional limitations of the judiciary require rejecting the claim that the "essential" aspect of such a vast and complex regulatory scheme can be severed without consequence, and fully in keeping with congressional intent. Whatever Congress's intent, it was not to delegate to the courts the authority to make health care policy.

In short, if this Court finds that the individual mandate exceeds Congress's authority under the Constitution, it is at the very least clear that the Act's guaranteed-issue and community-rating reforms must also fall, as the United States concedes. But as demonstrated above, the individual mandate is "essential" to much more than just those two sets of reforms. For the reasons explained, the approach that best preserves the separation of powers would be to invalidate the Act in its entirety, and to allow Congress to balance its policy preferences to address the Nation's healthcare problems within constitutional boundaries.

CONCLUSION

For the foregoing reasons, if this Court finds that the individual mandate is unconstitutional, it should also hold that the remainder of the PPACA is nonseverable from the mandate.

Respectfully submitted,

ROBIN S. CONRAD
SHANE B. KAWKA
KATHRYN COMERFORD TODD
NATIONAL CHAMBER LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

K. LEE BLALACK II
(Counsel of Record)
lblalack@omm.com
BRIAN D. BOYLE
ANTON METLITSKY
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

January 2012

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

IN THE
Supreme Court of the United States

FILED
JAN 6 - 2012
OFFICE OF THE CLERK

NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, et al.,
Petitioners,
v.
KATHLEEN SEBELIUS, SECRETARY OF
HEALTH AND HUMAN SERVICES, et al.,
Respondents.

STATE OF FLORIDA, et al.,
Petitioners,
v.
UNITED STATES DEPARTMENT OF
HEALTH & HUMAN SERVICES, et al.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* COMPETITIVE ENTERPRISE INSTITUTE, THOMAS P. MILLER, JOSEPH R. ANTOS, CHRISTOPHER J. CONOVER, EARL L. GRINOLS, MICHAEL A. MORRISEY, TOMAS J. PHILIPSON, SCOTT E. HARRINGTON, JAMES C. CAPRETTA, ROBERT KAESTNER, AND JAMES W. HENDERSON IN SUPPORT OF PETITIONERS (SEVERABILITY ISSUE)

Of Counsel:

SAM KAZMAN
HANS BADER
COMPETITIVE ENTERPRISE
INSTITUTE
1899 L St. N.W.
12th Floor
Washington, D.C. 20036
(202) 331-1010

THOMAS M. CHRISTINA
Counsel of Record
JEFFREY P. DUNLAEVY
OGLETREE, DEAKINS, NASH,
SMOAK & STEWART, P.C.
Suite 500
300 North Main Street
Greenville, SC 29601
(864) 271-1300
tom.christina@ogletreedeakins.com
Counsel for Amici Curiae

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

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INTEREST OF THE *AMICI*

Amicus Curiae the Competitive Enterprise Institute ("CEI") is a non-profit organization dedicated to advancing the principles of limited government, free enterprise, and individual liberty.[1] Given its institutional mission, CEI has a substantial interest in the validity of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("PPACA"), as amended by Title I of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("HCERA," and collectively, "ACA" or "the Act"), including but not limited to the compulsory purchase requirement (referred to as the "individual mandate") found in Section 5000a(a) of the Internal Revenue Code of 1986 ("the Code"), added by ACA Title I, § 1501 ("the mandate").[2]

The individual *Amici Curiae* are Thomas P. Miller, Resident Fellow, American Enterprise Institute;

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[1] Pursuant to Rule 37.6, *Amici* affirm that no counsel for a party authored this brief in whole or in part; no such counsel or any party made a monetary contribution intended to fund its preparation or submission; and no person other than an *Amicus*, its members, or its counsel made such a monetary contribution. Each party has lodged with the Clerk's Office a blanket consent to the filing of briefs *amicus curiae* supporting any party or no party.

[2] CEI's attorneys authored briefs *amicus curiae* supporting Petitioners filed in the courts below. Brief of Governors Tim Pawlenty and Donald L. Carcieri as *Amici Curiae* Supporting Plaintiffs, *Florida ex rel. McCollum v. HHS*, 716 F.Supp.2d 1120 (N.D. Fla. 2010) (No. 10-00091); Brief *Amici Curiae* of Minnesota Legislators and North Carolina Legislative Leaders in Support of Plaintiffs-Appellees/Cross-Appellants, *Florida v. United States Department of Health and Human Services*, 648 F.3d 1235 (11th Cir. 2011) (Nos. 11-11021 & 11-11067) ("*Florida v. HHS*").

Joseph R. Antos, Resident Scholar, American Enterprise Institute; Christopher J. Conover, Research Scholar, Duke University Center for Health Policy & Inequalities Research; Earl L. Grinols Distinguished Professor of Economics, Baylor University; Michael A. Morrisey, Director, Lister Hill Center for Health Policy, School of Public Health, University of Alabama at Birmingham; Tomas J. Philipson, Daniel Levin Professor of Public Policy Studies, The Harris School, University of Chicago; Scott E. Harrington, Alan B. Miller Professor of Health Care Management and Insurance and Risk Management, Wharton School, University of Pennsylvania; James C. Capretta, Fellow, Ethics and Public Policy Center; Robert Kaestner, Professor, Institute of Government and Public Affairs, University of Illinois and Professor, Department of Economics, University of Illinois; and James W. Henderson, Ben Williams Professor in Economics, Baylor University. Each of them is a health care public policy and/or health care law expert who has concluded that Titles I and II of the Act[3] will impede the goal of expanding the percentage of the population with effective and affordable access to healthcare and/or will have adverse economic market consequences disproportionate to any public advantages that might be conferred by the Act.

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[3] The phrase "Title I" as used in this Brief with reference to PPACA is defined to avoid confusion that might result from the fact that Title X of PPACA consists of emendatory instructions with respect to Titles I through IX of PPACA. Accordingly, when used with respect to PPACA, the phrase "Title I" refers to the text resulting from Title I as modified in accordance with Title X. The phrase "Title I," when used in reference to the ACA, means Title I of the PPACA (as defined above), as amended by Title I of the HCERA.

SUMMARY OF ARGUMENT

If the provision of the Act establishing the mandate is unconstitutional, the relief granted cannot be based on severing any part of it from the balance of Title I. That provision cannot be severed from the balance of the Act consistently with *Champlin Refining Co. v. Corporation Comm'n of Oklahoma*, 286 U.S. 210, 235 (1932), because Congress could not have adopted the Act without the mandate, and because the House of Representatives adopted a rule ("the PPACA Rule") requiring itself to vote on the Senate's version of the PPACA only as a package deal, thus disabling itself from adopting the PPACA without the mandate. Thus, the unconstitutional provision cannot be severed from the balance of Title I.

Substantively, the sections of the Act Congress grouped together as Title I are a unified, self-contained, and interrelated set. As a set, they establish and promote healthcare Exchanges created under Title I, Subtitle D. Exchanges are the market-related mechanisms that Congress intended would accomplish the Act's coverage, quality, and affordability goals with respect to a specific subset of the population. By design, Title I's sections function in coordination with each other to achieve these objectives. The substantive interrelatedness apparent from the face of these provisions is confirmed by regulatory guidance under the Act.

The interrelatedness of Title I's provisions, the Congressional findings in the Act, and the remainder of the legislative record establish that without the mandate, Title I would not have been adopted; would not be fully operative as law; and could not function in the manner Congress intended. Severing the mandate from the balance of Title I would entail denying effect to the PPACA Rule and disregarding Congressional findings in favor of less-reliable evidence on the questions at hand. Both steps are inconsistent with precepts in prior severability opinions of this Court. Prudential concerns also militate strongly against severing the mandate from the balance of Title I.

ARGUMENT

I. IF THE PROVISION ESTABLISHING THE MANDATE IS UNCONSTITUTIONAL, REMAINING PROVISIONS OF TITLE I CANNOT BE DECLARED VALID.

In cases beginning with *Champlin, supra,* this Court has decided the threshold question of severability a now-familiar formulation:

> Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law.

286 U.S. at 234. *See, also, e.g.*, *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987).

An answer to *Champlin*'s first question can be based on concluding from historical facts that Congress could not have adopted the balance of an act without the unconstitutional provision.[4] There is a sufficient basis not to sever an unconstitutional provision from an act if a legislative bargain to include the unconstitutional provision was required to garner majority support for the act. *See, e.g., Leavitt v. Jane L.*, 518 U.S. 137, 141 (1996) (applying Utah law). *Cf. Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (noting importance of considering the role of the unconstitutional provision "in the original legislative bargain"); *cf., also, Legal Services Corp. v. Velazquez*, 531 U.S. 533, 560-62 (2001) (Justice Scalia, dissenting) (objecting to severance remedy that "eliminate[s] a significant *quid pro quo* of the legislative compromise").

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[4] When the phrase "would not" is applied in a given case with reference to Congress's "will" (*i.e.*, its intent as manifested by its desires), then *Champlin* analysis can involve a hypothetical. *Ayotte v. Planned Parenthood of Northern New England*, 546

Congress would not have adopted the Act without the mandate provision because it *could not* have done so. This conclusion can be drawn directly from the political context in which the Act was adopted, *see, e.g., See, gen'ly, e.g., Brown wins Massachusetts Senate race* (Jan 19, 2010), http://articles.cnn.com/2010-01-19/politics/massachusetts.senate_1_senate-democrats-coakley-senate-seat?_s=PM:POLITICS, ("Brown's victory strips Democrats of the 60-seat Senate supermajority needed to overcome GOP filibusters . . . Senate Democrats needed all 60 votes in their caucus to pass the health care bill, and the loss of one seat imperils generating that support again for a compromise measure worked out with the House."); *and* CNN Transcript, March 21, 2010, http://transcripts.cnn.com/TRANSCRIPTS/1003/21/se.04.html.

Congress's inability to adopt the Act without the mandate provision is established on a more formal basis by the House of Representatives' adoption of

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U.S. 320, 330 (2006) ("After finding . . . a portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of its statute to no statute at all?").

H.Res. 1203, 111th Cong., 2d Sess. (Mar. 21, 2010) ("the PPACA Rule"), before it took up and adopted H.R. 3590, as amended by S. Amendment No. 2786 (December 24, 2009) ("the Senate version of PPACA"). H.Res. 1203, ¶¶ 2-3, prohibited amending the Senate version of PPACA, as approved by what at the time was a filibuster-proof Senate. The Senate version of PPACA included the individual mandate in ACA § 1501. By adopting the PPACA Rule, the House limited itself to voting on the Senate version of PPACA on an all-or-nothing basis, including Section 1501. Thus, giving effect to the PPACA Rule, the remainder of Title I cannot be declared valid because the mandate cannot be severed from the balance of the Act as a whole.[5]

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[5] The Court of Appeals' opinion seems to posit a judicial duty, based at least in part on a respect for separation of powers, to salvage acts of Congress by severing unconstitutional provisions from the balance of an act. *Florida v. HHS*, 648 F.3d at 1320-21 ("we *must* 'strive to salvage' acts of Congress by severing any constitutionally infirm provisions "while leaving the remainder intact.") (emphasis added), *citing Ayotte*, 546 U.S. at 329. However, separation of powers concerns cannot lead to a duty stated in the such absolute terms. Severability is a remedial issue. *See, e.g., Ayotte*, 546 U.S. at 328 ("We turn to the question of remedy. *Cf.* D.H. Gans, *Severability as Judicial Lawmaking*, 76 Geo. Wash. L. Rev. 639, 643 (2008) ("Severance occurs in the remedial moment . . . [S]everability should be seen as part of the federal common law of constitutional remedies . . .") (footnote omitted). As such, its exercise lies within the judicial power just as Congress's adoption of a bill for presentment to the President falls within the legislative power. Thus, taking separation of powers concerns into account on the facts of a given case requires a more nuanced approach. And, as *Carter v. Carter Coal*, 298 U.S. 238, 312-16 (1936), illustrates, the decision to sever can be exercised so as to sever part but less than all of the balance of an act consistently with this Court's precedents. While *Amici* urge that the Act as a whole be declared invalid, they also

II. THE PROVISION ESTABLISHING THE MANDATE SHOULD NOT BE SEVERED FROM THE BALANCE OF TITLE I, BASED ON FOUR CONSIDERATIONS IN ADDITION TO THAT DISCUSSED IN POINT I.

A. The Sections of Title I Constitute a Unified and Discrete Set of Provisions That, Based on their Substance, Are Interrelated in Organization, Structure, Purpose, and Regulatory Method.

Title I is a unified and discrete set of provisions interrelated at a bedrock level by their substance. An especially high degree of confidence attends this conclusion because the interrelationship of Title I's provisions can be shown as to each of four analytically distinct features: their common subject matter; their shared purpose; the carefully integrated timing of their effective dates; and the coordination of their roles in the creation and promotion of an important regulatory mechanism for achieving the Act's overall goals, *i.e.*, the Exchanges created under Title I, Subtitle D, §§ 1311 and 1321.

Especially as seen in the context of the Act's structure, the integration of Title I's provisions is easily recognized. The Act as a whole seeks to expand the percentage of Americans with health coverage meeting a federally determined substantive floor and to make that coverage more affordable. Subgroups of Americans obtain health coverage from

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recognize that the Court might be persuaded by Respondents and their *amici* to fashion declaratory relief based on a more restrained exercise of the power to sever. Point II addresses that possibility.

different sources, depending partly on demographic factors such as age, employment (including self-employment), income, and the like.

Congress drafted the Act so that discrete and largely non-overlapping subsets of its provisions applied to subcategories of Americans defined by the way their members typically obtain coverage. In keeping with this organizational premise, Congress grouped ACA §§ 1001 through 1563 not just into a Title, but into a single set of sections based on the particular group to which its provisions are addressed. That group consists of Americans whose coverage customarily is employment based, (employees, the self-employed, and their dependents),[6] and usually is obtained either in the insurance market or through self-insured employer-sponsored plans.[7]

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[6] As used herein, "employment based" means resulting from employment or self-employment. For brevity's sake, members of this group will be referred to as "employees."

[7] The insurance market consists of the individual market and the group market, and the latter is further divided into the small group market and the large group market. The individual market is very important to self-employed individuals and to some extent also to common law employees of employers that do not sponsor health plans. It is expected that the individual market will play an enhanced role for common law employees under the Act. In An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act (Nov. 30, 2009) ("CBO 11 30 09"), at 20, CBO reported that under the then-current version of the Senate measure that became PPACA, the number of purchasers in the individual market would rise from 14 million to 32 million between 2010 and 2016, and some of the new entrants into that market "would have employment-based coverage . . . under current law." Unfortunately, the analysis did not specify how much of the predicted growth in the individual market CBO attributed to the migration of common law employees from employer-sponsored plans

This structural principle informs every Subtitle of Title I. For example, Subtitle A includes market reforms applicable to individual policies and plans sponsored by employers subject to the Public Health Service Act. *See, e.g.*, ACA, Title I, Subtitle A, § 1001, amending, *inter alia*, Section 2714 of the Public Health Service Act ("PHSA").[8] Subtitle B establishes a funding program to support medical coverage for retired employees. ACA, Title I, Subtitle B, § 1102. Subtitle C adds additional market reforms to those adopted in Subtitle A, including one that prohibits pre-existing condition exclusions. *See* PHSA § 2704, added by Title I, Subtitle C, § 1201.

In the same vein, Subtitle D, which provides for the creation of the Exchanges as health insurance markets, also opens the Exchanges to small employers in 2014 and allows for access by large employers thereafter. ACA, Title I, Subtitle D, § 1312(f) and (2)(B). Subtitle

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to Exchange-purchased individual coverage. As discussed below, Title I includes financial incentives favoring the purchase of individual coverage from an Exchange. *See, e.g.*, Code § 36B, as amended, added by ACA § 1402. The provisions of Code § 36B(c)(2)(C), establishing special rules related to individuals eligible for employer-provided coverage, establish that common law employees are among those for whom the incentives were intended.

[8] Significantly, by adding a new Section 715(a)(1) to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Act causes the PHSA amendments to apply to health plans subject to ERISA. Almost every group health plan sponsored by a private sector employer (other than church plans) is subject to ERISA. *See* ERISA §§ 3(1), (3), and 4, 29 U.S.C. § 1002(1), (3), and 1003. Moreover, ERISA covers these plans precisely because they are employer-sponsored plans covering the employees or former employees of the plan sponsor in their capacities as such. ERISA § 3(1), (4)-(7), 29 U.S.C. § 1002(1), (4)-(7).

E creates a tax credit available for small employers to help defray the cost of providing coverage to employees. Code § 45R, added by ACA Title I, Subtitle E, § 1421. Subtitle F creates an "employer mandate," by establishing that an assessable payment is due from a large employer if any of its full-time employees is certified to the employer by the Exchange as having purchased health insurance through the Exchange under circumstances that triggered an individual tax credit or cost-sharing reduction, if the employer did not offer all its full time employees health coverage or (although the employer does offer health coverage) it does not meet the Act's affordability and value standards. ACA Title I, Subtitle F, § 1512; *see, also*, ACA Title I, Subtitle D, §§ 1301-02, 1311, 1321.

Even Subtitle G, housing so-called "Miscellaneous Provisions," adheres to the same employment-based organizational principle. For example, Title I, Subtitle G, § 1558 amends the Fair Labor Standards Act to add a new Section 18C of the Fair Labor Standards Act. Section 18C is a non-retaliation rule to protect an employee from employer retaliation when the employee "received a credit under section 36B of the Internal Revenue Code of 1986 [added by Title I, Subtitle F, § 1401] or a subsidy under [Title I, Subtitle F] section 1402 of this Act . . ."

The provisions of Title I also are substantively interrelated by their common purpose, the means by which the purpose is accomplished, and the carefully choreographed timing of their effective dates. These interrelationships are most visible by first recognizing that Title I's provisions can be divided into stages based on when they become operative. This approach highlights how the functions of the various sections of

Title I are coordinated with each other, *cf.* CBO 11 30 09 at 1 (noting staging effect), particularly in promoting the role of the Exchanges created under Subtitle D as instrumentalities of reform. Congress considered the role of the Exchanges as new marketplaces for coverage crucial to reforming the markets currently patronized by employees (including for this purpose the self-employed).

The first stage of Title I is embodied largely within Subtitles A and C, which became operative beginning no later than 2011 ("the 2011 stage"). The sections in the 2011 stage stimulate primary demand for coverage among employees by making coverage relatively more valuable. This goal is achieved primarily by a set of provisions in Subtitle A that enhance the perceived and actual value of coverage by: (a) eliminating lifetime benefit maximums; b) restricting annual benefit maximums before phasing them out completely in 2014; (c) effectively extending dependent coverage of children to age 26 without regard to student status, marital status, and economic dependence; (d) requiring first dollar coverage of preventive health services; (e) restricting waiting periods for coverage of pre-existing conditions (as a prelude to prohibiting them altogether); (f) requiring that emergency medical services provided out of network must be covered on a par with such services rendered in network; and other miscellaneous requirements and prohibitions applicable to the terms of coverage. See ACA, Title I, Section 1001, amending PHSA § 2711 *et seq.*, and Subtitle C, § 1201, adding additional PHSA provisions.

These provisions enhance the economic value of being covered in highly visible ways by eliminating or curbing pre-Act terms of coverage employees found particularly frustrating in the past. This feature of Subtitles A and C serve the goal of making coverage not only more choiceworthy but also more often chosen. For example, PHSA § 2715, added by Title I, Subtitle A, § 1001 requires developing a common format for general use by insurers and employers to explain the terms of coverage they offer, in part to "demystify" insurance terminology. Use of this on the Exchanges will be required under ACA § 1311(d)(4)(E).[9]

The second stage is embodied largely in Subtitles D, E, and F, which become effective beginning on January 1, 2014. Sections of these Subtitles function by (a) increasing the economic level of the Act's stimulation of primary demand, as begun in Subtitles A and C; (b) requiring the establishment of the Exchanges with territorial franchises covering each state; and (c) steering consumers selectively toward the Exchanges as preferred markets for coverage satisfying the statutorily induced demand.

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[9] As part of the first stage, provisions of Title I, Subtitle B include temporary measures to preserve and enhance coverage before the Exchanges open. Significantly, those measures are highly coordinated with the advent of Exchange-available coverage. For example, Title I, Subtitle B, § 1101 provides for subsidies to high risk insurance pools that will transition their program participants to Exchange-based coverage in 2014.

Subtitle B also provides an internet portal or other mechanism "through which a resident of any State may identify affordable health insurance coverage options in that State." Thus, Title I, Subtitle B, § 1103, effectively creates a what might be called this scaled-down prototype of a Subtitle D Exchange. Subtitle D requires that "proto-Exchange" be used as a model for the real thing. *See*, ACA Title I, Subtitle D, § 1311(c)(4) (requiring HHS to "continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal").

The precise operation of these sections to produce these effects will be discussed below, but this is the appropriate place to note that this is the stage where, when, and how the mandate fits into the picture. The consumer's perceived economic self-interest in being covered is enhanced in the first stage by the actual and consumer-perceived higher value of coverage brought on by the consumer-friendly sections of Subtitles A and C and then intensified by tax subsidies in the second stage. The mandate "teams up" with these economic promptings by adding a legal obligation to have coverage meeting the Ac's standard. The path of least resistance for discharging the obligation of the mandate is the purchase of coverage from an Exchange.

Subtitle E offers tax credits conditioned on purchasing coverage through an exchange. ACA §§ 1401 (individual tax credit) and 1421 (small business tax credit). Subtitle D promotes consumer preference for Exchange-purchased coverage through non-monetary means. For example, Exchanges will provide their clientele free of charge the services of coverage store concierges, called "Navigators," to help customers choose Exchange-available coverage products. ACA, § 1311(d)(4).

In concert with sections in Subtitles A and C, Subtitle D also reduces the availability of non-Exchange coverage, thereby eliminating coverage vehicles that might compete with Exchange-available products. PHSA § 2707(a), added by Title I, Subtitle C, § 1201, prohibits insurers from offering coverage on or off an Exchange unless it meets the floor standards of ACA § 1302(a). Similarly, some provisions of Subtitles A and C will make it increasingly difficult for certain private-sector employers to continue offering coverage under a pre-Act self-insured group health plan, partly because compliance is costly. *See, e.g.,* the more elaborate and expensive claim and review requirements under PHSA § 2719, added by ACA, Title I, Subtitle A, § 1001.[10]

Regulations issued under Subtitle C, § 1251, establish additional impediments to the continuation of pre-Act employer-provided plans into 2014, when they might then compete with Exchanges as an alternative source of the "minimum essential coverage" an individual is required by law to obtain under the mandate. Section 1251 establishes something akin to an individual's right to continue coverage under a pre-ACA plan he or she likes. As interpreted by the Respondents, however, Section 1251 allows for the possibility that a pre-ACA plan can *lose* this grandfathered status as the result of post-enactment events such as increasing copayments, reducing employer subsidization by more than 5%, or even failing to assert grandfathered status. As explained by the Respondents, one purpose of creating these possibilities for losing grandfathered status is reducing the possibility that employees will choose coverage unwisely if an employer-sponsored self-insured plan remains available to them in 2014. *See, e.g.,* Group

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[10] Not all of the Subtitle A and C market reforms apply to every employer-provided plan. *See* ACA, Title I, § 1251 (establishing a rule for identifying plans that are not subject or not fully subject to some market reforms in Subtitles A or C, and providing that the term "grandfathered plan" refers to such plans as a result). However, as discussed below, interim regulations promulgated by Respondents will artificially shrink the member of employer provided plans considered to have immunity from portions of these market reforms.

Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rules With Requests for Comments, Preamble, 75 FR 34538, 34548 (June 17, 2010) ("Grandfather Preamble").[11]

In fact, these provisions represent a legislative "twofer," because they do more than help to increase the Exchanges' market-share, thereby bolstering the Exchanges' ability to reduce the cost of coverage by adding to their bargaining clout with carriers. They also simultaneously serve Congress's substantive goal of promoting coverage subject to a higher floor than the one established by Subtitles A and C alone.

Thus, the provisions of Title I reflect a choreographed and integrated strategy for regulating the terms, value, marketing, purchase, and operation of individual and employer-provided group coverage through government-established Exchanges that will enforce federally established or federally approved rules. *See* Act, Title I, Subtitle D, Part II, § 1311 (relating to the establishment of Exchanges by a State) and Part III, § 1321 (federally established Exchanges). One additional function of Exchanges harks back to the ACA's basic organizational principle (defining subgroups of the American population by demographic factors determining how they typically obtain coverage): an Exchange is required to shunt would-be insurance customers to state programs for which the Exchange determines they are eligible. ACA § 1311(d)(4)(F).

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[11] Respondents' concerns about bad employee coverage choices were based on the work of behavioral scientists that documents the existence of an "inertia effect" which might lead employees to re-register time after time to continue coverage under their pre-ACA employer-sponsored plans, despite the availability of coverage alternatives objectively better suited to their needs. Grandfather Preamble, 34548. The Grandfather Preamble attributes the behavioral anomaly of subjective choices that vary from objective realities to various sources such as resistance to change, procrastination, a lack of relevant information, or a simple desire to avoid what they perceive as a risk associated with switching to a new plan. *Id.*

Staging effects aside, there is another factor at work here. Substantively, the entire set of provisions in Subtitles A, C, and F that stimulate primary demand for coverage is, in turn, just one element of a larger set of provisions in Title I designed to encourage patronage of the Exchanges created under Subtitle D to satisfy that demand. For example, Title I, Subtitle E, §§ 1401-1402 stimulate demand specifically for Exchange-available coverage by subsidizing the cost (and in some cases also enhancing the value) of individual coverage only if purchased on an Exchange. *Id.*, Subtitle E, §§ 1401-1402. No corresponding subsidies are available for the purchase of individual coverage outside the Exchanges. In a similar vein, Subtitle E creates a small-business tax credit for small employers, but it is conditioned on the purchase of employee group coverage from an Exchange. *See* Code § 45R, added by Title I, Subtitle E, § 1421.[12] Perhaps of the greatest significance in this regard, the penalty for violation of the employer mandate is triggered if and only if one or more of the employer's employees purchases subsidized coverage from the Exchange.

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[12] The cost of the added demand stimulus created under Subtitle E was expected to be offset in part by funds received under Code § 5000a(b), added by Title I, Subtitle F. Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Hon. Harry Reid, Senate Majority Leader, Chart 2, p. 6 (Dec. 19, 2009), http://www.cbo.gov/doc.cfm?index=10868&type=1. This expectation, in turn, was the basis for PPACA's deficit-reduction finding in Title I, Subtitle G, § 1563.

To summarize: just as the last of the interim measures in Subtitle B is scheduled to wink out of existence, the Exchanges established under Subtitle D will open. Using the market clout conferred on them by the combined effects of Subtitles A, C, and F, and by the monetary subsidies directed their way under Subtitle E, the Exchanges in their capacity as markets will become the primary agencies that administer and enforce federally mandated coverage provisions, market regulations, access rules, disclosure requirements, price-and profit-controls, and the other permanent regulatory apparatus created under Title I. As if to testify to the inseparability of the provision creating the mandate from the related language creating the Exchanges, the Act provides that the Exchanges will decide in the first instance whether a person is exempt from the mandate. Not surprisingly, this authority is the result of a feature or provision of the Act, the language of which is distributed among sections found in several Subtitles of Title I. *See* Code Section 5000a(a) (coverage mandate for "applicable individuals"); (d)(1) and (2)-(4) (defining "applicable individual" with respect to three exempt categories); Title I, Subtitle D, § 1311(d)(4)(H)(ii) (requiring an Exchange to issue certificates attesting that an individual is exempt from the individual mandate because he or she satisfies the criteria for an exemption from the category "applicable individual" as defined in Code

§ 5000a(d)(2)-(4)), *and cf.* Title I, Subtitle E, § 1411 (review of exemption certifications).[13]

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[13] Title I, in turn, is related organizationally and substantively to sections Congress chose to place in other Titles. One potentially significant example of that phenomenon can be found in the effective dates of a provision of Section 1902 of the Social Security Act ("SSA"), 42 USC § 1396a(gg), added by ACA, Title II, § 2001. As amended by the Act, Section 1902 conditions each state's continued eligibility for federal payments under SSA § 1903(a) on the state's compliance with a requirement not to have in effect any "eligibility standards, methodologies, or procedures under the State [Medicaid] plan" that are more restrictive than their pre-PPACA counterparts. This condition is applicable from the date of PPACA's enactment until the date "the Secretary determines that an Exchange established by the State under [PPACA §] 1311 . . . is fully operational." The fact that this provision of Title II relates to a term defined in Title I does not detract from *Amici*'s characterization as largely self-contained. Sections do not bear a one-to-one correspondence with provisions, except perhaps by coincidence, and Congress was not required to repeat the words in Section 1311 in Title II as part of a provision encompassing Section 2001.

The significance of the end date of the "maintenance of effort" provision in SSA § 1902 is best appreciated by considering how an Exchange may be created under the Act. Section 1311 authorizes and requires each state to establish an Exchange. ACA § 1311(b)(1). Section 1321 permits Respondent HHS to create an Exchange within a state as soon as HHS determines that the state is not making sufficient progress toward complying with Section 1311's mandate by 2014. Because the establishment of an Exchange under ACA § 1321, unlike the establishment of an Exchange under ACA § 1311, does not cause the condition in SSA § 1902 to lapse, ACA § 2001 could be considered part of a provision that prods state legislatures and executives to adopt promptly measures needed to establish an Exchange under ACA § 1311 that will meet with HHS's approval. If such a provision of the Act as set forth in Sections 1501 and 2001 (among others) is unconstitutional on both the grounds advanced by the States and the other Petitioners, *Amici* urge that the minimum appropriate remedy would include invalidating every remaining

The interrelationship of the mandate with the balance of Title I is not the result of happenstance. The public legislative record shows that, from the outset, the individual mandate was one component of a set of measures the Congressional Budget Office predicted to the incoming 111th Congress would stimulate primary demand for health coverage. *See* Internal Revenue Code of 1986, § 5000a(a), added by Title I, Subtitle F, § 1501, and *cf., Key Issues in Analyzing Major Health Insurance Proposals*, 53-54 (Congressional Budget Office, December 2008) ("*Key Issues*") (noting a base level of compliance with a rule of law that can be enhanced by enforcement). The Act's findings confirm that Congress anticipated this very effect. Title I, Subtitle F, § 1501(a)(2).

Consider, for example, the "consumer protection" standards of Subtitles A and C. These were understood in advance as mechanisms to stimulate primary demand for coverage among employees in precisely the fashion evident from the text of those standards. *Key Issues, supra*, 43-53. This is so because these standards enhance the perceived value of individual and employer-provided coverage by restricting eligibility waiting periods, opening dependent coverage to children up to age 26, mandating additional claims procedures, banning lifetime maximums, and requiring other value-added substantive and procedural provisions. *Cf. Key Issues, supra,* at 51-53. Assessable payments under Code § 5000a(b) to be made by certain individuals who fail to have minimum essential coverage as defined in Subtitle F, is a financial

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inseparable provision of the Act, which in this scenario would include all of Title I plus other portions of the Act considered inseparable from that part of the offending provision contained exclusively within Section 2001.

disincentive for non-covered status and was understood in advance as a means to make non-covered status comparatively less attractive financially. *Cf. Key Issues, supra,* at 51-53. Although Code § 5000a(b) is not the mandate proper, Code § 5000a(b) is related to the rest of Title I in precisely the same fashion as the mandate, *i.e.*, as one of several means working in tandem to increase the percentage of employees and their dependents with minimum essential coverage by affecting their behavior.

Title I's status as an integrated whole also is confirmed by temporary and proposed regulations issued under the authority of its sections. For example, the preamble to interim final rules under Section 1251 explicitly refers to reconciling that Section's provisions with other policy goals (presumably appearing in other sections). Grandfather Preamble, *supra*, 75 FR at 34548. The IFR creates rules under Section 1251 of the PPACA to ease the transition to "market reforms" embodied in various other provisions in Title I of the Affordable Care Act.

In one case, Respondent Department of the Treasury issued proposed regulations under Code Section 36B, added by ACA § 1401(a) (amended by a provision in Title X when the Senate adopted the PPACA), the substance of which is quite literally ruled out by Code § 36B's language. *See* Code § 36B(b)(2) and subparagraph (A) (always resulting in a tax credit equal to zero if coverage otherwise triggering the tax credit is purchased from an Exchange established by HHS under Section 1321 instead of an Exchange established by a state under Section 1311). *Cf.* Preamble to Prop. Treas. Reg. §§ 1.36B-1 *et seq.*, 76 Fed. Reg. 50931 (Aug. 17, 2011) ("The proposed regulations provide that a taxpayer is eligible for the credit for a taxable year if . . . enrolled in one or more qualified health plans through an Exchange established under section 1311 or 1321"). While no explanation for this statement was given, negating the text of an ACA section could only have been based on taking other sections of the Act or policies emanating from them into account.

The structure of the Act as a whole also suggests that its individual titles be treated as indivisible for purposes of severability. First, the subject matter of the Act is so broad that it all but required addressing coverage and cost issues separately with respect to employees (once again understood to include the self-employed); pre-retirement age beneficiaries of public programs such as Medicaid; and the Medicare-eligible population, which correspond to sections of the Act as grouped into Titles. Second, section-by-section parsing is particularly unattractive as an alternative, especially considering the extraordinarily high number of sections in the Act. Third, treating Title I as a unit for severability purposes hews more closely than section-by-section parsing to at least one possible explanation of the use of the singular forms of the words "bill" and "law" in Article I's description of the law-making process. Moreover, it was Congress that chose to divide the provisions of the Act into Titles, grouped together by subject matter. Aggregating interrelated provisions on that basis certainly is not irrational. Thus, Congress's division of the ACA into Titles provides a textual basis in the Act for this Court to consider severability of those provisions on the same basis.

B. Congressional Findings Confirm That Title I Was Intended and Designed to Function Only As a Whole.

The indivisibility of Title I is confirmed by Congress's statutory findings that

> (C) The requirement [*i.e.,* the individual mandate], together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.
>
> (D) The requirement achieves near-universal coverage . . .
>
> (F) . . . By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums. . . . [and]
>
> (I) . . . [I]f there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

42 U.S.C. § 18091(a)(2), added by ACA, Title I, Subtitle F, § 1501(a)(2). Indeed, the conclusion that Congress would not have adopted the Act without the individual mandate can rest entirely on Congress's finding that the individual mandate is "essential" to creating what Congress called "effective health insurance markets." The findings place the individual mandate in sharp contrast to the limited, discrete and independent provisions that this Court has severed without any additional modifications to the underlying statute. *Cf., e.g., Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684-85 (1987) (discrete legislative veto provision severed from unrelated statutory provisions); *United States v. Jackson*, 390 U.S. 570, 585-591 (1968) (single criminal penalty severed from criminal statute containing numerous alternative penalties). Moreover, the findings also show that the balance of Title I cannot function as intended without the mandate, confirming Respondents' concession to that effect, even if that concession applies only to some but not all of the balance of the sections in Title I.

C. Title I Would Not Have Been Adopted Without the Individual Mandate.

Congress simply would not have adopted Title I without the individual mandate. This conclusion follows from H.Res. 1203 and the other parliamentary maneuvers attending the Act's passage, even if the sole purpose those maneuvers was to protect only Title I of the PPACA from amendment. Moreover, it follows from Congress's findings that it did not wish to adopt Title I unless the mandate were included.

It is difficult to escape the conclusion that Title I *inevitably* would include the mandate. The individual mandate was part of the very atmosphere in which all of the 111th Congress's healthcare reform measures were considered. The inclusion in the Act of Section 1501, the bearer of the mandate, cannot be accurately understood as an historical fact if it is considered to be merely a by-product of the parliamentary necessities confronting the Act's supporters following Sen. Brown's election. More than a year before the Massachusetts special Senatorial election, the CBO published an extensive model for healthcare reform which stressed the importance of an individual mandate. *See, Key Issues, supra*, Chapter 2, 27-57, and esp. 48-54. The analytical approach in the *Key Issues* document was employed throughout the ensuing legislative process. *See, e.g.,* CBO 11 30 09, *supra*, at 10 n.11; 11 n.13,; 17 n.25; 19 n.27; and 20 n.28. Most significantly for the interrelatedness of the mandate with other language in Title I, the November 30, 2009 report confirms the discussion in *Key Points* that the simple existence of the mandate itself would lead some people to obtain coverage, while the "penalties that would be levied" under a version of Code § 5000a(b) would induce compliance by others. *See* CBO 11 30 09 at 20, first bullet point; *and cf. Key Issues* at 53 ("Many individuals . . . would comply with a mandate, even in the absence of penalties, because they believe in abiding by the nation's laws."). Moreover, an individual mandate was included in the only competing version of a healthcare reform bill adopted by either chamber during the 111th Congress. *See* the Affordable Health Care for America Act (H.R. 3962), Title V, § 501, as adopted by the House on November 7, 2009.

D. Prudential Considerations Militate Strongly Against Disregarding Either Congress's Findings or the PPACA Rule in Applying the Power to Sever to Fashioning a Remedy in this Case.

Finally, a court may decline to sever an invalid provision from other unobjectionable portions of an enactment, even if the other provisions can function independently, if "the invalidated provision could be regarded as part of a legislative compromise, extracted in exchange for the inclusion of other provisions of the statute." *Leavitt v. Jane L.*, 518 U.S. 137, 141 (1996) (applying Utah law). *Cf. Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (noting importance of considering the role of the unconstitutional provision "in the original legislative bargain"). The less open and transparent the lawmaking process, the less confident this Court can be in expecting to identify all the provisions that would not be present in an Act but for a legislative compromise. Moreover, without a public record of each step in hammering out the final text of an act, no one reasonably could expect this Court to decide whether it has fully achieved the goal of respecting the results of legislative compromises because, in principle, that goal could require an unpredictable number of recursive applications of that precept to an indeterminate series of ever smaller versions of an act.

Title I as adopted by the Senate resulted from negotiations conducted behind closed doors among members of a 60-person majority in the Senate. HCERA's amendments to Title I resulted from negotiations behind closed doors between the leadership of the Senate and House majorities. Unlike the House-Senate conference committee process that might have been anticipated when the Senate adopted PPACA, there is no public record of the processes by which the final text of the ACA was hammered out. Congress effectively (if unintentionally) precluded access to the information necessary for reaching a conclusion on the basis of "political realities" differing from Congress's own assessment that the individual mandate is "essential" to the creation of the Exchanges and integral to the goals of Title I as a whole (if not the entire Act). Viewed in light of these considerations, taking the Act's findings at face value and giving effect to the PPACA Rule entails neither surrendering to empty formalism nor indulging in "poetic justice." Instead it directly serves the fundamental bases of severability as a remedial device.

CONCLUSION

An unconstitutional provision of the Act should not be severed from the remainder of the Act. At a minimum, it should not be severed from those portions of the remainder of the Act (including at least the balance of Title I) from which it is inseparable under *Champlin*.

Respectfully submitted,

THOMAS M. CHRISTINA
Counsel of Record
JEFFREY P. DUNLAEVY
OGLETREE, DEAKINS, NASH, SMOAK & STEWART, P.C.
Suite 500
300 North Main Street
Greenville, SC 29601
(864) 271-1300
tom.christina@ogletreedeakins.com

Counsel for Amici Curiae

Of Counsel:

SAM KAZMAN
HANS BADER
COMPETITIVE ENTERPRISE INSTITUTE
1899 L St. N.W.
12th Floor
Washington, D.C. 20036
(202) 331-1010

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

IN THE

Supreme Court of the United States

NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, *et al.*,
Petitioners,

v.

KATHLEEN SEBELIUS, *et al.*,
Respondents.

STATE OF FLORIDA, *et al.*,
Petitioners,

v.

UNITED STATES DEPARTMENT OF
HEALTH & HUMAN SERVICES, *et al.*,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR COURT-APPOINTED AMICUS CURIAE SUPPORTING COMPLETE SEVERABILITY (SEVERABILITY)

H. BARTOW FARR, III
Counsel of Record
FARR & TARANTO
1150 18th Street, N.W.
Suite 1030
Washington, DC 20036
(202) 775-0184
farrandtaranto@aol.com

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

QUESTION PRESENTED

Whether, if the minimum coverage provision of the Patient Protection and Affordable Care Act is held unconstitutional, it is evident that Congress would want the Act's guaranteed issue and community rating provisions – or the rest of the Act in its entirety – to be declared void and unenforceable.

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IN THE

Supreme Court of the United States

Nos. 11-393 and 11-400

NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, *et al.*,
Petitioners,
v.
KATHLEEN SEBELIUS, *et al.*,
Respondents.

STATE OF FLORIDA, *et al.*,
Petitioners,
v.
UNITED STATES DEPARTMENT OF
HEALTH & HUMAN SERVICES, *et al.*,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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BRIEF FOR COURT-APPOINTED AMICUS CURIAE SUPPORTING COMPLETE SEVERABILITY (SEVERABILITY)

INTEREST OF THE *AMICUS CURIAE*

This brief is submitted in response to the Court's order of November 18, 2011, appointing counsel to brief and argue in support of the judgment of the United States Court of Appeals for the Eleventh Circuit that the minimum care provision of the Patient Protection and Affordable Care Act, 26 U.S.C. § 5000A, is severable from the entirety of the remainder of the Act.

SUMMARY OF ARGUMENT

1. Petitioners and the United States are asking this Court to invalidate perfectly lawful provisions of a federal statute. But the Court undertakes that kind of extreme judicial intervention only in rare cases. In fashioning a remedy for an unconstitutional statutory provision or application, the Court generally "refrain[s] from invalidating more of [a] statute than is necessary," *United States v. Booker*, 543 U.S. 220, 258 (2005) (internal quotation marks omitted), instead "severing any problematic portions while leaving the remainder intact." *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161 (2010) (internal quotation marks omitted). Thus, so long as the remaining provisions of a statute are "fully operative as a law," *New York v. United States*, 505 U.S. 144, 186 (1992) (internal quotation marks omitted), the Court allows the valid parts of a statute to continue in effect "[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid]." *Id.* (internal quotation marks omitted).

Relying on language from *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987), petitioners argue that the ultimate severability inquiry should be "whether the statute [without the unconstitutional provision] will function in a *manner* consistent with the intent of Congress." *Id.* But that language, read literally, would point the analysis in precisely the wrong direction. Because Congress naturally intends a statute to "function" with all of its provisions intact, petitioners' suggested approach would invite a judicial comparison between the statute without the unconstitutional provision and the statute in its original form. As the Court has frequently made clear, however, that is not the right inquiry: the proper severability question is whether "the legislature [would] have preferred what is left of its statute to *no statute at all.*" *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 330 (2006) (emphasis added); *Free Enterprise Fund*, 130 S.Ct. at 3161-62; *Leavitt v. Jane L.*, 518 U.S. 137 (1996) (per curiam). Here, therefore, the precise question before the Court is whether it is "evident" that, faced with the unconstitutionality of the minimum coverage provision, Congress would prefer to have no Affordable Care Act at all – or, to take the United States' narrower position, an Act with no guaranteed issue and community rating provisions – rather than an Act with only the minimum coverage provision removed.

2. Although the United States argues, as a threshold matter, that the Court cannot – or, alternatively, should not – conduct severability analysis with respect to provisions that do not directly affect the plaintiffs, its reasoning is unconvincing. To begin with, to the extent that the United States bases its argument on a lack of Article III power, it is mistaking the place of severability analysis in the resolution of a given case. When the Court considers whether invalidation of one statutory provision should lead to invalidation of some or all of the remaining provisions, it is not deciding a new case or controversy, or a new claim for relief, but rather is seeking to fashion an appropriate remedy for the

violation it has found. *See Ayotte*, 546 U.S. at 330. That traditional exercise of equitable powers requires the Court, not just to weigh the effect of possible remedies on the parties before it, but "also [to] take account of the public interest," *U.S. Bancorp Mortgage Co. v. Bonner Mall Partnership*, 513 U.S. 18, 26 (1994), an obligation that, in this context, requires an examination of whether Congress – which has a fuller perspective on all the relevant statutory interests – would want the remaining provisions to stand. *See Ayotte*, 546 U.S. at 330 ("a court cannot use its remedial powers to circumvent the intent of the legislature") (internal quotation marks omitted). Severability analysis is thus a necessary component of the Court's remedial authority, and nothing in *Printz v. United States*, 521 U.S. 898 (1997) – which makes no reference to either standing or Article III – requires a separate standing determination before undertaking it.

As for remedial discretion: we agree with the United States that the Court is not *required* to decide the severability question in this case. But, in our view, the Court should decide it, just as the courts below did. Deferral of the severability question will lead to needless uncertainty about the enforceability of other provisions of the Act, putting in question the legitimacy of already effective provisions as well as casting doubt over ongoing preparation for statutorily required changes in the health insurance market. It would be a more fitting use of the Court's remedial discretion to address those issues now, rather than to leave them for resolution at a later time.

3. The primary severability question advanced by petitioners and the United States is whether Congress would want the guaranteed issue and commu-

nity rating provisions to stand independently of the minimum coverage provision. We think that the answer is yes. As the United States itself recognizes, the guaranteed issue and community rating provisions "were the Act's core reforms of the insurance market," US Brief 24 (Minimum Coverage Provision), and they were put in place specifically to open the health insurance market to millions of people who had been unable to acquire affordable coverage because of their poor health. Even leaving aside the usual presumption in favor of severability, therefore, it seems improbable that, if the minimum coverage provision were to be held unenforceable, Congress would prefer to put many of these consumers back where they were before passage of the Act, facing the prohibitively high costs and outright denial of coverage that were standard features of the market that Congress was trying to change. At the very least, the Court should require clear evidence to that effect.

That kind of evidence is lacking here. Although petitioners (but not the United States) initially rest their inseverability argument on the fact that Congress included a severability clause in a different health care bill but not in the one that became law, that fact does not mean much for several reasons. First, there is no explanation for the difference in treatment, and congressional silence is almost always a poor indicator of congressional intent. *See Mead Corp. v. Tilley*, 490 U.S. 714, 723 (1989). Second, both the House and Senate drafting manuals state that it is not necessary to include severability clauses in legislation, acknowledging that the Court applies a presumption in favor of severability anyway.

Petitioners (now joined by the United States) also rely on the Act's express findings about the centrality of the minimum coverage provision to health care reform, *see* 42 U.S.C.A. §§ 18091(a)(1), (2)(A)-(J), but those findings are of limited value on the question of severability. That is because the findings, by their terms, are aimed at a very different question: whether the minimum coverage provision is so "essential" to other provisions of the Act (as well as to other laws) that it should be regarded as part of a broader regulatory scheme for purposes of Commerce Clause analysis. The findings plainly demonstrate that Congress saw the minimum coverage provision as integral to its regulation of interstate commerce, but it would be entirely possible for Congress to take that position and yet hold the complementary view that, if the minimum coverage provision were found unconstitutional, the remaining provisions of the Act should continue in force. Indeed, that congressional preference for severability seems particularly likely for those provisions of the Act – like guaranteed issue and community rating – that were regarded as the principal means of bringing new insureds into an otherwise risk-based insurance market.

Finally, petitioners and the United States rely on an empirical argument of sorts, asserting that, without the minimum coverage provision, future health insurance markets would be severely distorted by adverse selection, resulting in a potential "death spiral" that Congress would have sought to avoid. But the Congressional Budget Office has recognized that the Act contains a number of provisions that "would tend to mitigate that adverse selection." Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 19 (2009). For example, the Act permits insurers to establish limited enrollment periods each year to discourage the uninsured from waiting until they are sick before purchasing insurance. *See* 42 U.S.C.A. § 300gg-1(b)(1). And, even more importantly, the Act provides generous subsidies to enable low-income people – many of whom are young and in relatively good health – to purchase insurance. *See* 26 U.S.C.A. § 36B. As a consequence, various estimates of premium increases in an insurance market with continued guaranteed issue and community rating, but without the minimum coverage provision, range from approximately 10 percent to slightly more than 25 percent, falling short of the kind of "death spiral" that petitioners and the United States are warning about.

Petitioners and the United States also point to the pre-Act experiences of several States that adopted guaranteed issue and community rating without a coverage mandate, suggesting that Congress would be wary of having the former without the latter. But the dramatic premium increases cited for those States are well beyond those predicted under the federal Act without the minimum coverage provision, presumably in part because none of the States provided for subsidies of the kind and magnitude contemplated by the federal law. And, it is noteworthy that, despite their experiences, a number of the States in question have elected not to do away with guaranteed issue and community rating, or to impose a mandate, indicating that removing barriers to coverage of the uninsured remains of central importance. Petitioners and the United States have not presented clear evidence that Congress would make a different choice.

4. Apart from its severability clause argument, petitioners' case for invalidating the entire Act rests upon an initial premise that the guaranteed issue and community rating provisions will themselves be invalidated, causing a chain reaction of inseverability with respect to the remainder of the Act. Since that premise is incorrect, the rest of the Act should stand. Moreover, it is apparent that other provisions of the Act can continue to operate even without the minimum coverage provision. *See* US Br. 28-40. For example, while implementation of the new Medicaid provisions and the provisions related to employer-subsidized insurance will be affected to some extent if the minimum coverage provision is not in place, those provisions – which cover the majority of insured Americans – will still be able to achieve much of what Congress sought to accomplish. And there is no good justification for striking down any of the numerous provisions of the Act that are totally unaffected by the existence or non-existence of the minimum coverage provision.

ARGUMENT

It is a striking use of judicial power for a federal court to declare that perfectly valid provisions of a law passed by Congress are void and unenforceable. Before taking such action, therefore, the Court should have clear evidence that Congress, faced with the unconstitutionality of one part of a statute, would have wanted some or all of the remaining parts struck down as well. But there is no such evidence here. The provisions that the United States and petitioners together seek to have invalidated – the guaranteed issue and community rating provisions – were specifically designed by Congress to provide important benefits to many uninsured people, often with serious pre-existing conditions, who have been denied (or quoted extremely high prices for) needed insurance coverage. And, while it is true that Congress expected those provisions to work in concert with the minimum coverage provision, it is far from evident that the benefits of extending coverage to those previously excluded from the insurance market cannot still be realized, to a significant degree, even if the minimum coverage provision is held invalid. The guaranteed issuance and community rating provisions thus should remain in place, and, if they do, the case for striking down all of the remaining provisions – most of which have little or nothing to do with the minimum coverage provision – essentially falls of its own weight. As a result, this Court should limit its excisions from the statute to the minimum coverage provision – along with its related penalty provisions – and nothing more.[1]

I. THE COURT SHOULD SELDOM INVALIDATE STATUTORY PROVISIONS THAT ARE NOT THEMSELVES UNCONSTITUTIONAL

A. This Court has made clear that, in eliminating unconstitutionality from a federal statute, it "must 'refrain from invalidating more of [a] statute than is necessary.'" *United States v. Booker*, 543 U.S. 220,

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[1] The United States points out that invalidation of the minimum coverage provision would naturally lead to invalidation of the textually dependent penalty provisions, which are specifically triggered by failure to obtain or maintain minimum coverage. *See* US Br. 54-55 n.23. (Citations to all briefs are to Severability briefs unless otherwise noted.) For simplicity, references in this brief to invalidation of the minimum coverage provision should be read to include the penalty provisions as well.

258 (2005), quoting *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (plurality opinion). As the Court recently observed, "'[g]enerally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem,' severing any 'problematic portions while leaving the remainder intact.'" *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161 (2010), quoting *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 328-29 (2006). Thus, for example, when a statutory provision is constitutional as applied to one set of facts but unconstitutional as applied to another, the Court has said that "'partial, rather than facial, invalidation is the required course,' such that a 'statute may . . . be declared invalid to the extent that it reaches too far, but otherwise left intact.'" *Ayotte*, 546 U.S. at 329, quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985). Likewise, "[w]henever an act of Congress contains unobjectionable provisions separable from those found to be unconstitutional, it is the duty of this Court to so declare, and to maintain the act in so far as it is valid." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (internal quotation marks omitted); *El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909).

This basic rule is sound for several reasons. To begin with, a reluctance to strike down valid statutory provisions fits most closely with the justification for judicial intervention in the first place. The Court is not "a body with revisory power over the action of Congress," *Muskrat v. United States*, 219 U.S. 346, 361 (1911), but invalidates federal statutes only in the performance of its "most important and delicate duty" to determine whether a federal statute conflicts with the supreme authority of the Constitution. *Id.*

In that context, the Court, while necessarily overriding the congressional will, is exercising a recognized Article III power to assure that the legislative branch has acted within constitutionally prescribed limits. *See United States v. Raines*, 362 U.S. 17, 20-21 (1960); *Marbury v. Madison*, 1 Cranch 137, 177-180 (1803). By contrast, use of the judicial power to strike down entirely constitutional provisions of a statute has no independent Article III grounding, and should typically be invoked only when it is plain that the Court is, in fact, carrying out the intention of Congress itself.

Second, and relatedly, the rule favoring severability is more consistent with fundamental remedial principles. It is well accepted that, when government action has been found to conflict with the Constitution, "[t]he scope of the remedy must be proportional to the scope of the violation, and the order must extend no further than necessary to remedy the violation." *Brown v. Plata*, 131 S.Ct 1910, 1940 (2011). Thus, while the Court, in fashioning an equitable remedy, can and does take account of the broader public interest, *see, e.g.*, *U.S. Bancorp Mortgage Co. v. Bonner Mall Partnership*, 513 U.S. 18, 26 (1994); pages 20-24 *infra*, the basic rule is that the "remedy must . . . be limited to the inadequacy that produced the injury in fact that the plaintiff has established." *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 353 (2006). Applying that principle, it will be clear in many cases – including this one – that the Court can redress the plaintiff's injury simply by prohibiting enforcement of the statutory provision that offends the Constitution.

Third, a remedy striking down only the unconstitutional provision does the least amount of damage to the statute that Congress enacted. In explaining its severability doctrine, the Court has emphasized that "we try not to nullify more of a legislature's work than is necessary, for we know that '[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people.'" *Ayotte*, 546 U.S. at 329, quoting *Regan*, 468 U.S. at 652 (plurality opinion). By including an inseverability clause, Congress can always specify that it prefers to have broader nullification, but the scarcity of inseverability clauses suggests that Congress is generally willing to have its laws remain effective and enforceable, even if they must operate without provisions found to violate the Constitution. And, in that event, the future legislative work of revising the statute to account for the Court's decision – if Congress elects to follow that course – can begin with almost all of the original statute already in place.

B. To implement these principles of limited judicial invalidation, the Court has adopted a demanding test. So long as the remaining provisions of the statute are "'fully operative as a law,'" *New York v. United States*, 505 U.S. 144, 186 (1992), quoting *Alaska Airlines*, 480 U.S. at 684, the Court will allow the provisions to function "[u]nless it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid]." *New York*, 505 U.S. at 186. *See Free Enterprise Fund*, 130 S.Ct. at 3161 (same).

In the past half-century, the Court has applied that standard with considerable rigor, rarely finding distinct statutory provisions to be inseverable. Indeed, it is notable that, while petitioners rely heavily on *language* from recent severability cases, they rely far less on *holdings* in such cases. *See* States Br. 36-42;

NFIB Br. 30-36. They cite only one case decided in the past 70 years – *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172 (1999) – in which the Court could have eliminated the illegal portion of a law simply by excising it but nevertheless went on to strike down other parts of the law as well. For the most part, petitioners' invocation of recent authority points either to cases where the Court severed the unconstitutional provision or application and left the rest of the law untouched (*see, e.g.*, *Free Enterprise Fund*, 130 S.Ct. at 3161-62; *Ayotte*, 546 U.S. at 328-31; *New York*, 505 U.S. at 186-87; *Alaska Airlines*, 480 U.S. at 684-97; *INS v. Chadha*, 462 U.S. 919, 931-36 (1983); *Regan*, 468 U.S. at 652-55 (plurality opinion)) or to cases where the Court, while not limiting its remedy to a single provision or application, went further only because it concluded that fixing the unconstitutionality would require it to add words to the statute or otherwise rewrite the statute in unacceptable ways. *See, e.g.*, *Randall v. Sorrell*, 548 U.S. 230, 262 (2006); *see also Wyoming v. Oklahoma*, 502 U.S. 437, 459-61 (1992); *Bowsher v. Synar*, 478 U.S. 714, 734-36 (1986). The first type of case does the opposite of what petitioners seek here, and the second deals with a problem that is not present in this case.

Petitioner NFIB and some amici curiae stress, in various ways, that the Act without the minimum coverage provision is not precisely the Act passed by Congress and signed by the President. *See* NFIB Br. 32-36; Family Research Council Amicus Br. 26-28; Assoc. of American Physicians Amicus Br. 9-30. But, if they mean by this to argue that, upon invalidation of one provision, all remaining provisions should automatically be deemed inoperative, their argument runs contrary to the fundamental premise on which severability law has long been founded: that "[t]he unconstitutionality of a part of an act does not necessarily defeat or affect the validity of its remaining provisions." *Champlin Refining Co. v. Corporation Comm'n of Okla.*, 286 U.S. 210, 234 (1932); *see also Free Enterprise Fund*, 130 S.Ct at 3161. Moreover, any such rule would cause needless upheaval. Given the breadth and complexity of much modern legislation, a rigid requirement of inseverability not only would dismantle large parts of the United States Code but – because it likely would turn on whether the lawful and unlawful provisions were contained within a single bill – also would produce arbitrary and inconsistent results.

If NFIB's and amici's argument is that Congress should be presumed to want only the law that it passed, that, too, is an idea whose time has come and gone. As their cited cases demonstrate, this Court has sometimes taken the position that a law enacted by Congress is presumptively indivisible. *See, e.g., Carter v. Carter Coal Co.*, 298 U.S. 238 (1936); *Williams v. Standard Oil of La.*, 278 U.S. 235 (1929). In *Carter Coal*, for instance, the Court declared that "[i]n the absence of [a severability] provision, the presumption is that the Legislature intends an act to be effective as an entirety – that is to say, the rule is against the mutilation of a statute; and if any provision be unconstitutional, the presumption is that the remaining provisions fall with it." 298 U.S. at 312. That statement of the rule reflected the Court's similar approach in a prior case, where, while noting its duty "to maintain the act in so far as it is valid," *El Paso*, 215 U.S. at 96, the Court nevertheless stated that the burden was on those seeking severability to show that "it is plain that Congress would have enacted the legislation [if the unconstitutional provision were omitted]." *Id.* at 97. But that is no longer the law. As we have noted, the Court now applies the opposite presumption, leaving otherwise valid provisions in force "[u]nless it is evident that the Legislature would *not* have enacted those provisions" without the invalid one. *Free Enterprise Fund*, 130 S.Ct. at 3161 (emphasis added) (internal quotation marks omitted).

Petitioner NFIB tries a variation on the "one bill" theme, suggesting that the Court should be concerned about the risk that severing unconstitutional provisions will amount to "judicial usurpation." NFIB Br. 34. But it is an odd theory of deference that calls upon the Court to invalidate all of Congress's work, rather than just the part that is contrary to the Constitution.[2] And, while NFIB is certainly correct that the Court has been careful not to intrude too far into the legislative domain – by, say, inserting new language to eliminate a constitutional problem, *see Randall*, 548 U.S. at 262 (declining to "write words into the statute") – the Court need have no concern about engaging in such legislative-type activities in this case because enjoining operation of the minimum coverage provision will, without any additional rewriting of the Act, eradicate the alleged unconstitutionality.

C. Petitioners' primary attempt to tilt the balance against severability is to insist that the ultimate inquiry is "whether the statute [without the unconstitutional provision] will function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685 (emphasis in original). *See* States Br. 38, 42, 44, 50, 52; NFIB Br. 31, 37, 39, 40, 42, 45. But that broad formulation – which the Court has not relied upon in any subsequent decision – must be approached with caution, lest it swallow the basic rule of severability. Taken literally, the inquiry suggested by *Alaska Airlines* would mean that only the most trivial provisions of a law could be deemed severable, given that excision of anything more significant would inevitably change the "manner" in which the statute as a whole was meant to operate. It is very doubtful that *Alaska Airlines* – which, after all, emphasized the Court's duty to "refrain from invalidating more of the statute than is necessary" (*id.* at 684) and set forth the proper severability-favoring standard ("whether it is evident that the Legislature would not have enacted those provisions," *id.*) – meant to restrict severability to that extent.

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[2] NFIB relies upon *Clinton v. City of New York*, 524 U.S. 417 (1998), a case striking down a line-item veto by the President. *See* NFIB Br. 34. But that case cuts against NFIB's position. In utilizing a line-item veto, the President is actually deleting lawful provisions of legislation passed by Congress, just the kind of questionable invalidation that NFIB is seeking here.

A second problem with an overly literal application of the *Alaska Airlines* language is that it would focus attention on the wrong question. By its terms, the quoted phrase invites a comparison between the judicially modified statute and the statute originally enacted by Congress, which presumably demonstrated the "manner" in which Congress intended the statute to work. But that is not the right comparison. As the Court has noted, the relevant question is whether "the legislature would have preferred what is left of its statute to *no statute at all*." *Ayotte*, 546 U.S. at 330 (emphasis added); *Free Enterprise Fund*, 130 S.Ct. at 3161-62.

The decision in *Leavitt v. Jane L.*, 518 U.S. 137 (1996) (per curiam), makes clear just what the proper inquiry should be. There, the Court rejected an argument that, in conducting severability analysis, it should be guided by the legislature's "unified intent" in passing the statute as a whole, stating that "[t]his mode of analysis, if carried out in every case, would operate to defeat every claim of severability." *Id.* at 143. As the Court observed, "[e]very legislature that adopts, in a single enactment, provision A plus provision B intends (A+B); and that enactment, which reads (A+B), is invariably a 'unified expression of that intent,' so that taking away A from (A+B), leaving only B, will invariably 'clearly undermine the legislative purpose' to enact (A+B)." *Id.* The critical point, of course, is that the desired option of having the entire statute, including the unconstitutional provision ("A"), is no longer available. So, "[t]he relevant question is whether the legislature would prefer not to have B if it could not have A as well." *Id.*

The Court's decisions since *Alaska Airlines* demonstrate that the "*manner* consistent with the intent of Congress" language was not meant to rewrite basic severability analysis. In *Booker*, for example, the Court replaced a system of mandatory criminal sentencing with a discretionary sentencing system, even though it was readily apparent that Congress had intended the system to work in a mandatory "manner." *See generally* 543 U.S. at 246-67. Indeed, the Court acknowledged that both its remedy and another proposed remedy "would significantly alter the system that Congress designed," *id.* at 246, and frankly stated that its role was to decide which of the possible remedies "would deviate less radically from Congress' intended system." *Id.* at 247. Similarly, in *Free Enterprise Fund*, the Court eliminated a provision protecting members of the Public Company

Accounting Oversight Board from removal by the Securities and Exchange Commission, 130 S.Ct. at 3161-62, despite the fact that Congress had taken considerable pains to insulate the Board from removal by the Commission. Again, the critical question was not whether the modified statute would still operate in the intended manner – in that respect, it plainly would not – but whether "Congress, faced with the limitations imposed by the Constitution, would have preferred *no Board at all* to a Board whose members are removable at will." 130 S.Ct. at 3162 (emphasis added).

Severability analysis thus must begin with a recognition that the statute as enacted by Congress cannot stand. And, once it is acknowledged that the law inevitably will be altered, a preference for preserving the valid portions of the statute is the best of the possible options. After all, Congress enacts legislation because it believes that pre-existing law is inadequate, and it often seeks to attack various aspects of an unacceptable prior situation in the same legislation. A severability doctrine that returns the law to its earlier state, therefore, is likely to frustrate at least some of Congress's objectives, and should be avoided unless Congress itself has provided a strong indication – that is, unless it is "evident" (*Free Enterprise*, 130 S.Ct. at 3161) – that it would rather have the old law rather than the valid portions of the new one. As we discuss in sections III and IV below, that kind of strong evidence is lacking here.

II. THIS COURT HAS THE POWER TO ADDRESS, AND SHOULD ADDRESS, WHETHER THE REMAINDER OF THE ACT CAN CONTINUE IN EFFECT WITHOUT THE MINIMUM COVERAGE PROVISION

Before turning to the question whether the guaranteed issue and community rating provisions can stand independently of the minimum coverage provision, we must first address the United States' argument that the Court has no power to reach that issue.[3] Relying on *Printz v. United States*, 521 U.S. 898 (1997), the United States claims that petitioners, despite their standing to challenge the minimum coverage provision, cannot seek invalidation of other provisions of the Act unless those provisions have an identifiable effect on them. The Eleventh Circuit did not expressly discuss this issue, but must be taken to have rejected the United States' position since it resolved the severability question on its merits. And, in the end, we think that the court of appeals was right to reject it: although the Court has the flexibility not to reach severability issues in appropriate cases, it necessarily has the power to decide them in the exercise of its remedial authority.

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[3] The United States' argument is not limited to a lack-of-power theme, *see* US Br. 15-16 (referring to "prudential standing," "equitable relief," "facial challenges," and "judicial restraint"), and we address the Government's position that the Court "should not" consider severability issues at pages 22-23 *infra*. However, the United States asserts in the relevant section heading that the Court "may not" address severability issues, US Br. 14, and its reliance on concepts like "Article III," US Br. 15, "injury in fact," US Br. 16, and "cases and controversies," US Br. 16, appears to be part of a challenge to the Court's power to decide severability in this case.

Insofar as the United States is arguing that Article III bars the Court from considering the validity of provisions that do not affect petitioners, its view misapprehends the role of severability analysis in the resolution of an ongoing case. When the Court considers whether other, independently valid provisions of a statute should remain in force, it is not deciding a new "claim" for relief, or a request for a "different form" of relief, both of which would require the plaintiffs to establish standing anew. *See, e.g., DaimlerChrysler*, 547 U.S. at 352 ("a plaintiff must demonstrate standing for each claim he seeks to press"); *Friends of the Earth, Inc. v. Laidlaw Environ. Serv.*, 528 U.S. 167, 185 (2000) ("a plaintiff must demonstrate standing separately for each form of relief sought"). Rather, it is deciding the proper scope of equitable relief for the constitutional violation that the plaintiffs have already established. *See Ayotte*, 546 U.S. at 330. And, in making that determination, the Court is not limited to considering the interests of the plaintiffs and defendants. To the contrary, because the Court is exercising equitable powers, it must examine how various remedies might affect the public interest. *See U.S. Bancorp.*, 513 U.S. at 26 ("[a]s always when federal courts contemplate equitable relief, our holding must also take account of the public interest"); *United States v. Morgan*, 307 U.S. 183, 194 (1939) ("[i]t is familiar doctrine that the extent to which a court of equity may grant or withhold its aid, and the manner of moulding its remedies, may be affected by the public interest").

To carry out its remedial duties in proper fashion, therefore, the Court must consider, not just whether a particular remedy might be overly broad, but also whether too narrow a remedy – that is, an order limited just to invalidation of the unconstitutional provision – will adversely affect the larger public interest. And, because Congress is typically better positioned to recognize if removal of one provision in a statute would rightly lead to the incapacity of other provisions, the Court looks to see whether Congress has expressed any clear indication that the remaining provisions should be deemed unenforceable as well. *See Ayotte*, 546 U.S. at 330 ("a court cannot use its remedial powers to circumvent the intent of the legislature") (internal quotation marks omitted); *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 497 (2001) ("[a] court sitting in equity cannot ignore the judgment of Congress, deliberately expressed in legislation") (internal quotation marks omitted). To be sure, as we have discussed, *see* pages 9-18 *supra*, it will usually be the case that the judicially altered statute can still advance worthwhile statutory goals, even without the stricken provision, and thus the Court commonly leaves the remaining provisions undisturbed. But, in rare cases, removal of just the unconstitutional provision may so disrupt other interests, including those of parties not before the Court, that the better remedial course is to invalidate some or all of the remaining provisions as well. Either way, severability analysis is an essential component of determining what the proper remedy should be.[4]

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[4] Under the United States' view, the Court apparently could never take into account Congress's intention regarding statutory provisions that do not affect the plaintiffs, no matter how clear its intention might be. That rule would potentially lead to the strange situation in which the remaining provisions of a statute continued in full effect, even though Congress had included an express inseverability clause to prevent just such an outcome.

This case illustrates the point. Even as it makes its Article III argument, the United States also asserts that continued enforcement of provisions like guaranteed issue and community rating, in the absence of the minimum coverage provision, would seriously distort segments of the health insurance market. *See* US Br. 47-51. Yet, as we discuss later, *see* pages 25-29 *infra*, the effect of *deleting* those provisions would be to impose hardship on numerous uninsured people who stand to gain access to the insurance market as a result of insurance reform. Thus, the scope of the Court's remedial order is of considerable significance to third parties. And, regardless of how the Court ultimately weighs the potential consequences of different remedial choices, it would be an incomplete exercise of its equitable authority for the Court simply to disregard those consequences, restricting its consideration of possible benefits and burdens to the parties before it.

Finally, however, we note that remedial power is always characterized by flexibility. *See, e.g., Hecht Co. v. Bowles*, 321 U.S. 321, 329 (1944) ("[f]lexibility rather than rigidity has distinguished [equity jurisdiction]"). We thus agree with the United States insofar as it asserts that the Court is not *required* to decide the severability issues that petitioners raise. In general, if the Court believes that resolution of severability issues requires the perspective of parties not before the Court, nothing precludes the Court from deciding, on that remedial ground, to limit its invalidation to the unconstitutional provision or application itself. *See, e.g., United States v. National Treasury Employees Union*, 513 U.S. 454, 477-78 (1995). Equally, the Court may postpone any definitive severability analysis if, in the exercise of prudent discretion, it sees no particular harm to third party interests as a result of a remedy aimed simply at redressing the injury to the plaintiffs in the immediate case. Both of those resolutions amount to a kind of *de facto* severability – pending future challenges[5] – and remain among the remedial choices that the Court may elect in an appropriate case.

In our view, however, this is not an appropriate case. Postponement of a severability determination necessarily creates uncertainty about the governing law, and that kind of uncertainty would be especially detrimental here. As the United States points out, US Br. 29-30, many of the Act's provisions are already in effect, and many other provisions, such as those establishing the new insurance exchanges, require extensive advance planning. Still more provisions – in particular, the guaranteed issue and community rating requirements – are intended to provide new or expanded benefits to millions of people in need of health care. It would not be an optimal use of this Court's remedial discretion to leave the validity of those provisions in continuing doubt.

The decision in *Printz* did not change these basic remedial principles. Although the Court in *Printz* declined to address the severability of certain statutory provisions with no apparent effect on the plaintiffs, the relevant part of its opinion is limited to a single paragraph – not the usual format for announcing an important new doctrine – and the Court did not invoke either "standing" principles or "Article III," instead defining the issue as "a severability question." 521 U.S. at 935. Moreover, while the Court's observation that it "ha[d] no business answering" the severability question can certainly be read as suggesting a lack of power to answer it, that language can also be read as describing a proper exercise of discretion under the circumstances, where the potential impact of a limited decree on third parties (*i.e.*, leaving in place various waiting periods and notification requirements) was likely to be modest. Thus, despite the United States' submission, we believe that the Court has the power to decide – and should decide – the severability issues that petitioners have raised.

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[5] Contrary to the States' position, it is not especially difficult to imagine "what claim [a third party] would bring." States Br. 33. Plaintiffs could seek an injunction against a statutory provision that causes them injury, alleging that the provision is a) inseverable from a provision that has already been struck down on constitutional grounds and b) thus unenforceable against them.

III. THE GUARANTEED ISSUE AND COMMUNITY RATING PROVISIONS SHOULD REMAIN IN EFFECT EVEN WITHOUT THE MINIMUM COVERAGE PROVISION

The central severability question in this case is whether the guaranteed issue and community rating provisions should continue in effect even if the minimum coverage provision is struck down. *See* 42 U.S.C.A. §§ 300gg-1, 300gg-2, 300gg-3, 300gg-4(a) (guaranteed issue); 42 U.S.C.A. §§ 300gg(a)(1), 300gg-4(b) (community rating). *See also* US Br. 6 nn. 5&6, 54-55 n. 23. The United States and petitioners take the position that they should not, saying that the guaranteed issue and community rating provisions are so intertwined with the minimum coverage provision that they cannot stand independently. *See* US Br. 44-54; States Br. 47; NFIB Br. 36-40. In support, they make essentially three arguments: 1) that the absence of a severability clause – described by NFIB as the "removal" of a severability clause – shows that the provisions are interdependent (an argument that the United States rejects); 2) that Congress's express findings establish that the provisions are inseverable; and 3) that, as a practical matter, an insurance market with guaranteed issue and community rating, but without a minimum coverage provision, cannot function effectively because it will suffer from severe adverse selection, possibly producing a "death spiral."

In the end, these arguments are insufficient. Although the guaranteed issue and community rating provisions were meant to work together with the minimum coverage provision, and likely will operate less ideally without the minimum coverage provision, it does not follow that Congress, confronted with that prospect, would prefer to return to the prior health insurance system, where large numbers of people, in need of insurance but with pre-existing illnesses or conditions, were excluded from the market. That conjecture might be plausible if it were clear that a true "death spiral" would occur without the minimum coverage provision – driving so many healthy consumers out of the market that less healthy consumers would face unmanageable prices anyway – but, as we discuss in some detail, *see* pages 35-41 *infra*, that outcome is not at all certain. The Court thus should decline the invitation to strike down these important, lawful provisions. *See Regan*, 468 U.S. at 655 (plurality opinion) (declining to declare lawful provisions inseverable where "Congress' intent can in large measure be fulfilled without the [unconstitutional] requirement").

A. To assess whether Congress would prefer to go back to an insurance system without guaranteed issue and community rating, it is necessary to understand why Congress included those provisions in the first place. Although the majority of Americans get their health insurance through their employers (*see* Kaiser Family Foundation, *The Uninsured: A Primer*, at 3 (October 2011)) – where various forms of guaranteed issuance and community rating tend to be the rule, at least for large employers – individuals and families outside the employer-insurance market have traditionally faced a more unsettled marketplace. As the law stood before passage of the Act, insurers in most States were permitted to deny health insurance to people in poor health or with pre-existing conditions. *See* Linda J. Blumberg & Karen Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, at 2 (Urban Institute 2009). Moreover, if insurers did offer coverage, it was often at very high prices and might include a rider denying coverage for specified conditions. *See id.* To determine the risks for particular policies, insurers engaged in a process of medical underwriting that itself was costly, thus raising insurance prices. Lucien Wulsin, Jr. & Adam Dougherty, *Individual Mandate: A Background Report*, at 4 (2009).

The cumulative impact of these risk-specific practices was substantial. The Department of Health and Human Services recently estimated that "12.6 million non-elderly adults – 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market – were in fact discriminated against because of a pre-existing condition in the previous three years." Dept. of Health and Human Services, *Coverage Denied: How the Current Health Insurance System Leaves Millions Behind*, at 1 (2009). The HHS report noted that "a pre-existing condition does not have to be a serious disease like cancer or heart disease," and that "[e]ven relatively minor conditions like hay fever, asthma, or previous sports injuries can trigger high premiums or denials of coverage." *Id.* Given that expansive definition of pre-existing illnesses, it is not surprising to find that large numbers of people have them, or can expect to have them in the foreseeable future. Another Department of Health and Human Services analysis stated that "50 to 129 million (19 to 50 percent) of non-elderly Americans have some type of pre-existing health condition," up to 25 million of whom are uninsured. Dept. of Health and Human Services, *At Risk: Pre-existing Conditions Could Affect 1 in 2 Americans*, at 1 (2011). *See also id.* ("15 to 30 percent of people in perfectly good health today are likely to develop a pre-existing condition over the next eight years").

Congress was well aware of these coverage problems. A House Report discussing an earlier health care bill (H.R. 3200) recognized that "health insurers – particularly in the individual market – have adopted discriminatory, but not illegal, practices to cherry-pick healthy people and to weed out those who are not as healthy." H.R. Rep. No. 299, 111 Cong., 1st Sess. Pt. 3, at 92 (2009). The House Report listed a number of such practices, including "denying health coverage based on pre-existing conditions or medical history, even minor ones; charging higher, and often unaffordable, rates based on one's health; [and] excluding pre-existing medical conditions from coverage . . . ." *Id.* It noted that these and other actions by insurers have "severe economic consequences for those who have been unable to find affordable health coverage and for those who have coverage, but are under-insured." *Id.*

Congress thus made it a primary objective of the Act to remove insurance barriers for consumers in relatively poor health. Of particular relevance here, the Act requires that, subject to limited exceptions, "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage." 42 U.S.C.A. § 300gg-1(a). Furthermore, the Act specifies that an insurer "may not impose any preexisting condition exclusion with respect to such plan or coverage." 42 U.S.C.A. § 300gg-3(a). And, to prevent denials-in-fact caused by high premiums tied to health status, the Act imposes a community rating system, restricting (though not entirely eliminating) insurers' ability to vary their rates according to individual circumstances. *See* 42 U.S.C.A. §§ 300gg(a)(1)-(5), 300gg-4(b). The United States itself refers to these provisions as "the Act's core reforms of the insurance market . . . " US Br. 24 (Minimum Coverage Provision). *See also* H.R. Rep. No. 443, 111th Cong. 2d Sess. Pt 2, at 975-76 (2010) ("to protect families struggling with health care costs and inadequate coverage, the bill ensures that insurance companies can no longer compete based on risk selection").

The severability position taken by petitioners and the United States would put an end to these "core reforms." But that backwards-looking proposition properly carries a heavy burden. Indeed, even if there were no general presumption in favor of severability, it would still seem appropriate for the Court to insist upon a clear indication of Congress's intent before concluding that the severability result most consistent with congressional policy would be to deny coverage to many people that Congress indisputably meant to help. The arguments put forth by the United States and petitioners do not meet that standard.

B. At the outset, it is worth noting that the Act does not contain an inseverability clause, either a general one or one limited to the guaranteed issue and community rating provisions.[6] Although that omission does not merit great weight – Congress uses inseverability clauses infrequently enough that the absence of one is not especially probative – the fact remains that an inseverability clause is the clearest way for Congress to declare its intention that parts of a statute must stand or fall together. Congress could have availed itself of that opportunity in the Act, but it did not. Moreover, as petitioners point out, Congress fully anticipated legal challenges to the constitutionality of the minimum coverage provision, *see* States Br. 5-6, 58, so the lack of an inseverability provision cannot be attributed to the element of unforseeability.

Petitioners (opposed by the United States) do try to fashion a kind of makeshift inseverability clause, contending that prior "removal" (NFIB Br. 58) of a severability clause reveals Congress's intent to have the entire Act – not just the guaranteed issue and community rating provisions – treated as indivisible. *See* NFIB Br. 58; States Br. 58. But there are several problems with this argument. In the first place, the term "removal" is not an apt characterization of the drafting history. To be clear: the bill that was enacted into law never contained a severability clause and thus no severability clause was, or could have been, removed from it. Severability clauses were contained in (and not removed from) two different health-care bills, H.R. 3200 and H.R. 3962, but neither of those bills became the final version of the Act.

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[6] Neither the United States nor petitioners dispute that the guaranteed issue and community rating provisions can still be "fully operative as a law," *New York*, 505 U.S. at 186, in the relevant sense that there is no textual dependency on the minimum coverage provision. Cf. *Booker*, 543 U.S. at 245 (striking down review provision with no function other than to enforce unconstitutional provision). *See also* Note 1 *supra*.

To be sure, the inclusion of a severability clause in some bills and its absence in another bill might indicate that Congress did not want provisions of the latter bill to be severed. *See* States Br. 58. But it is hard to draw that inference here. The legislative record offers no explanation for why some health-care bills had severability clauses and the particular bill that became law did not, and speculation based on nothing more than congressional silence is properly regarded as treacherous. *See Kimbrough v. United States*, 552 U.S. 85, 103 (2007). Indeed, even if Congress had actually removed a severability clause from the law-making bill, that action, without any indication of the reason, would still carry little weight. As this Court has remarked, "'mute intermediate legislative maneuvers' are not reliable indicators of congressional intent." *Mead Corp. v. Tilley*, 490 U.S. 714, 723 (1989), quoting *Trailmobile Co. v. Whirls*, 331 U.S. 40, 61 (1947).

The general reluctance to rely on legislative silence makes especially good sense in the present context. As the Eleventh Circuit noted, both the House and Senate drafting manuals state that it is not necessary to include a severability clause in proposed legislation. *See* US Pet. App. 175a-76a. *See also* US Br. 42-43. Even without a severability clause, it is well understood that the Court will usually strike down only the invalid parts of a statute and leave the valid parts intact, thereby doing what a severability clause would instruct anyway. *See Free Enterprise Fund*, 130 S.Ct. at 3161; pages 9-18 *supra*. Thus, while the presence of a severability clause might help to reinforce the Court's customary practice, the absence of one hardly suffices to justify striking down a vast, multi-part statute in its entirety.

C. Petitioners (joined on this point by the United States) also rely on a seemingly more telling expression of congressional intent: explicit findings about the vital role of the minimum coverage provision. *See* States Br. 11-14, 45-46; NFIB Br. 36; US Br. 45-47. Those findings declare, among other things, that the coverage requirement is "essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C.A. § 18091(a)(2)(I). Furthermore, in the same finding, Congress explains that, "[b]y significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize . . . adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Id.* According to petitioners and the United States, these and other findings demonstrate that Congress saw the minimum coverage provision as inseverable from the guaranteed issue and community rating provisions.

This is a perfectly reasonable argument, but it has a significant weakness: the findings were not addressed to the issue of severability. Rather than providing guidance about what should happen if the minimum coverage provision were held unconstitutional, the evident purpose of the findings was to support Congress's position that the minimum coverage provision was, in fact, constitutional. The heading for the relevant subsection is "Effects on the national economy and interstate commerce," 42 U.S.C.A. § 18091(a)(2), and the nature of the findings themselves demonstrates Congress's intent to show the close relationship between the minimum coverage provision and interstate commerce. *See* 42 U.S.C.A. §§ 18091(a)(1), (2)(A)-(J). Indeed, the United States, in its separate minimum coverage brief, relies on these findings for just that purpose: to demonstrate that the minimum coverage provision "is an integral part of the Act's comprehensive regulation of the market in health care and health care financing." US Br. 27 (Minimum Coverage Provision).

This view of the findings is reinforced by several other textual clues. First, Congress's use of the term "essential" echoes the language of *United States v. Lopez*, 514 U.S. 549 (1995), where the Court, in holding that Congress had exceeded its power to regulate interstate commerce, specifically found that the object of Congress's regulation was, among other things, "not an essential part of a larger regulation of economic activity." 514 U.S. at 561. Given that background, the Act's findings were plainly drafted to set forth Congress's view that the minimum coverage provision should not be treated as a freestanding requirement for Commerce Clause purposes, but rather as an integral part of a larger regulatory scheme. As further support for that point, Congress also used the term "essential" to connect the minimum coverage provision to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, and the Public Health Service Act, 42 U.S.C. § 201 *et* *seq.*, saying that the coverage requirement was "an essential part of this larger regulation of economic activity," 42 U.S.C.A. §18091(a)(2)(H), language that tracks the *Lopez* wording exactly. As the Eleventh Circuit noted, however, no one argues that those Acts should be deemed inseverable from the minimum coverage provision. *See* US Pet. App. 184a-85a. It is thus apparent that, in the Act's findings, Congress was seeking to defend its reliance on Commerce Clause powers, not declaring its views about severability.

It is reasonable, of course, to ask whether the findings, though directed at the antecedent constitutional question, can also be read to answer the severability question. But the two questions are not the same. It is one thing to say that certain provisions of the Act are so interconnected that they should be considered as one activity for Commerce Clause purposes (the constitutional question), quite another to say they are so interconnected that, if Congress cannot have all of them, it would rather have none (the severability question). As we have discussed, if confronted with the severability question by itself, Congress in most cases will prefer to have an imperfect solution rather than no solution at all, and that seems particularly likely here, where the result of having no solution would be the denial of coverage to many people that Congress unquestionably wanted to assist.

D. Apart from the congressional findings, the bulk of the United States' and petitioner States' argument, joined for the most part by petitioner NFIB, rests upon an assertion that, as a practical matter, guaranteed issue and community rating cannot work in an acceptable way without the countervailing effects of the minimum coverage provision. *See* US Br. 45-51; States Br. 44-45; NFIB Br. 36-40. According to this view, the lack of a mandate to acquire insurance will result in various forms of adverse selection among people deciding whether to carry insurance, leading to higher premiums and to an unfavorable, even ruinous, skewing of the pool of insured people. To support this theory, petitioners and the United States rely on a handful of studies about the possible impact of a mandate-less health care system and on the experience of certain States that provided for guaranteed issue and community rating without a requirement to obtain health insurance. They then conclude that it is "evident" that Congress would not have wanted guaranteed issue and community rating without the minimum coverage provision.

Before responding to this argument in detail, however, we note that it calls for a severability analysis quite unlike any that the Court has undertaken before. The guaranteed issue and community rating provisions do not go into effect until 2014, and the portrayal of insurance markets facing a "death spiral" thus requires a heavy dose of conjecture. *See* Douglas W. Elmendorf, Director, CBO, *Analysis of the Major Health Care Legislation Enacted in March 2010*, at 9 (March 30, 2011) ("[t]he projections of the budgetary impact and other impacts of health care legislation are quite uncertain because assessing the effects of making broad changes in the nation's health care and health insurance systems . . . requires assumptions about a broad array of technical, behavioral, and economic factors"). Furthermore, this kind of predictive factfinding about the interplay of complex economic forces falls more naturally within the scope of legislative, rather than judicial, competence. *See generally Turner Broad. Sys., Inc v.*

FCC, 521 U.S. 622, 655 (1994). Those concerns might be alleviated, of course, if all the relevant studies showed that eliminating the minimum coverage provision by itself was so calamitous that no rational Congress could favor that limited remedy, but the studies are far from that definitive. To the contrary, they offer considerable reason for believing that the Act can achieve much of what Congress sought, even without the minimum coverage provision.

1. The United States and petitioners (in part) argue that, without the minimum coverage provision but with guaranteed issue and community rating, the health care market will be distorted by two forms of adverse selection. First, people with higher-than-average health care costs will sign up for insurance, raising the premiums for, and discouraging the purchase of insurance by, people with lower-than-average health care costs. Carried to extremes, this mutually reinforcing process can result in a "death spiral," producing an insurance market largely populated by unhealthy people paying extremely high premiums. Second, people will postpone their purchases of health care insurance until they are sick. That delay burdens insurance companies with the cost of paying for their resulting care without the compensating offset of premiums paid before they need care.[7]

The Congressional Budget Office has recognized, however, that the Act contains a number of provisions – of which the minimum coverage provision is just one – that will substantially restrain these effects. Thus, in a November 2009 report, the CBO first noted just what petitioners and the United States assert: that changes like guaranteed issue and community rating, viewed by themselves, "would make nongroup coverage more attractive to people who are older and who expect to be heavier users of medical care and less attractive to people who are younger and expect to use less medical care." Cong. Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 19 (2009) (CBO: *Analysis of Health Insurance Premiums*). The CBO went on, however, to point out that "several other provisions of the proposal would tend to mitigate that adverse selection." *Id.* For example, the CBO stated, "[t]he legislation would establish an annual enrollment period for new nongroup policies similar to that typically used by employers, which would limit opportunities for people who are healthy to wait until an illness or other health problem arose before enrolling." *Id. See also* NFIB Br. 15 n.18.

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[7] Petitioner NFIB does not support this argument, stating that "Congress' concerns about this kind of 'adverse selection' are both highly implausible and completely speculative." NFIB Br. 15 n.18. *See also* NFIB Br. 39 ("Congress greatly exaggerates this problem").

The enrollment provision referred to by the CBO directly addresses the second of the adverse selection concerns noted above: that the uninsured will wait to buy insurance until it is needed. By its terms, that provision permits insurance companies to "restrict enrollment in coverage . . . to open or special enrollment periods." 42 U.S.C.A. § 300gg-1(b)(1). If the uninsured choose to forego enrollment during the specified period, they must bear the risk of illnesses suffered prior to the next enrollment period. Even though that restriction will not eliminate all incentive for delaying insurance purchases – the uninsured would still receive emergency care if they cannot pay – it sharply raises the potential consequences of doing so.

Even more importantly, the CBO report observed that "[t]he substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people." CBO, *Analysis of Health Insurance Premiums*, at 19. Moreover, because of the subsidies' structure, "[t]he premiums that most nongroup enrollees pay would be determined on the basis of their income, so higher premiums resulting from adverse selection would not translate into higher amounts paid by those enrollees (though federal subsidy payments would have to rise to make up the difference)." *Id.* at 20. According to the CBO, "[t]hat arrangement would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." *Id.* Indeed, taking these mitigating influences into account, along with the minimum coverage provision, the CBO predicted that the extent of adverse selection "is likely to be limited, and many nongroup enrollees would be in fairly good health." *Id.*

The role of the premium subsidies – along with cost-sharing subsidies to limit out-of-pocket costs – is significant in several ways. Especially for those with the lowest income, and thus the greatest government support, the existence of the subsidies markedly changes the point at which it makes economic sense to purchase insurance. For potential purchasers, the relevant question about acquiring insurance is no longer whether their projected health costs will exceed the amount of the insurance premium, but whether their projected health costs will exceed *their share* of the insurance premium. Furthermore, given that uninsured low-income individuals are disproportionately young, *see* Kaiser Family Foundation, *The Uninsured: A Primer*, at 6 ("[y]oung adults whose low incomes make it more . . . difficult to afford insurance are especially likely to be uninsured"), it may be expected that, when they obtain insurance, their health care costs will be less than their total premiums (*i.e.*, their payment plus the government subsidy), creating a surplus for insurance companies writing the policies.

Several studies, in fact, have pointed out the suppressive effect that government subsidies are likely to have on premium increases, even without the minimum coverage provision. For example, a January 2012 Urban Institute study, comparing expected premiums under the Act without the minimum coverage provision to premiums under the Act with the minimum coverage provision, specifically noted that "[t]he effects of adverse selection in the exchange are mitigated by the large subsidized population." Matthew Buettgens & Caitlin Carroll, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care*, at 6 (Urban Institute 2012) (Buettgens & Carroll: *Eliminating the Individual Mandate*). Relatedly, an earlier Urban Institute report had noted that "[t]hose eligible for subsidies are on average younger than the population at large and have lower average costs." Matthew Buettgens, Bowen Garrett & John Holahan, *Why the Individual Mandate Matters*, at 6 (Urban Institute 2010). The authors thus concluded that "there would be a large pool of lower-than-average-cost enrollees in the exchanges with or without a mandate, moderating the effects of adverse selection." *Id.*

A study by the Lewin Group drew similar conclusions. *See* John F. Sheils & Randall Haught, *Without*

The Individual Mandate, The Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted, 30 Health Affairs No. 11, at 5 (Lewin Group 2011) (Sheils & Haught: *Without the Individual Mandate*). In that report, the authors stated that their simulation model showed "the stabilizing effect that premium subsidies can have on premiums and coverage." *Id.* Like the CBO, they recognized that the structure of the premium subsidy – covering the amount of the premium above a stated percentage of the recipient's income – meant that "people receiving premium subsidies under the act would be protected against most or even all of the premium increase." *Id.* That protection would, in turn, increase the take-up rate for coverage: "Because two-thirds of people with nongroup coverage are projected to receive subsidies, the effect of premium increases on coverage would be greatly reduced." *Id.* at 5-6.[8]

There is reason, therefore, to doubt whether, in the absence of the minimum coverage provision, a real "death spiral" actually will result. For its part, the January 2012 Urban Institute study estimated that "[w]ithout a mandate, but with robust exchange participation, overall nongroup premiums [would] rise about 10 percent due to adverse selection," Buettgens & Carroll: *Eliminating the Individual Mandate*, at 6, a figure that goes up to 12 percent if a low exchange preference is assumed. *Id.* (If the model is revised to assume a low degree of subsidy take-up as well, the figure jumps to 20 percent. *Id.*). The Lewin Group study, also comparing expected premiums under the Act without the minimum coverage provision to premiums with the provision, found that average premiums would increase by 12.6 percent. *See* Sheils & Haught: *Without the Individual Mandate*, at 5.[9] Noting that the estimate was "much lower than might be expected," *id.* at 7, the authors again explained that the figure reflected the high percentage of people eligible for subsidies and the protection against higher premiums built into the subsidy framework. Those factors "would reduce the coverage loss from lifting the mandate and restrain premium increases in the nongroup market." *Id.*

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[8] Petitioner NFIB argues that, without the minimum coverage provision, the Government's cost for premium subsidies would "skyrocket." NFIB Br. 49. But a CBO evaluation of the Act without the provision estimates that the cost of exchange subsidies would *decline* by $39 million. *See* Cong. Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, at 2 (June 16, 2010) (CBO: *Effects of Eliminating the Individual Mandate*); US Br. 40-41 n.19. That is because fewer people would sign up for insurance, a change in behavior that, while not advancing the goal of greater coverage, does reduce Government expenditures.

Two other studies have estimated somewhat larger premium increases without the mandate, at least compared to the first two Urban Institute figures.[10] The CBO has predicted that, if the minimum coverage provision were removed from the Act, "adverse selection would increase premiums for new non-group policies (purchased either in the exchanges or directly from insurers in the non-group market) by an estimated 15 to 20 percent relative to current law" (*i.e.*, the law with the mandate). CBO, *Effects of Eliminating the Individual Mandate*, at 2. And Professor Jonathan Gruber projected that premiums for individual policies would rise by 27 percent if the mandate were eliminated, *see* Jonathan Gruber, *Health Care Reform without the Individual Mandate*, at 2 (2011), although he found that premiums for family policies would increase by only 12.3 percent. *See* Jonathan Gruber, *Health Care Reform Is a Three-Legged Stool*, at 4 (Table) (2010); *see also id.* at 5 ("[t]he impact on family policies is more modest, as the selection effects are much stronger for young healthy singles").[11] Even those numbers, however, fall short of demonstrating that the health insurance market will be so negatively affected that Congress would plainly prefer a return to a market without guaranteed issue and community rating.

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[9] Breaking down that number more precisely, the Lewin Group study estimated that the price increases would be much higher for people not receiving subsidies – ranging from 26.2 percent to 34.9 percent, depending upon whether they purchase insurance through the exchanges – but considerably lower (7.7 percent) for people who did receive subsidies. *Id.*

[10] The figures in the various studies are not strictly comparable because, among other things, they reflect different time periods. *See* Buettgens & Carroll: *Eliminating the Individual Mandate*, at 3. Nevertheless, they provide a rough picture of what pricing changes might occur.

2. Petitioners and the United States also say that Congress would not have wanted to have guaranteed issue and community rating requirements without the minimum coverage provision because of the experiences of certain States that followed that course. *See* States Br. 12, 46; NFIB Br. 14 n.16; US Br. 47-

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[11] Taking a different tack, the Economists' amicus brief seeks to quantify the financial benefits to insurance companies that would be lost without the minimum coverage provision. Economists Amicus Br. 11-13. But, because the Economists combine benefits from the mandate and benefits from premium subsidies into a single figure, Economists Amicus Br. 12 n.6, they do not offer any figure for lost benefits occasioned by absence of the minimum coverage provision alone. Given the large subsidy amounts, the figures for removal of just the minimum coverage provision would be significantly lower.

51. *See also* America's Health Insurance Plans Amicus Br. 26-35; Texas Public Policy Foundation Amicus Br. 26-30. The immediate difficulty with that argument, however, is that the just-discussed studies reveal a substantial disparity between the cited States' experience and the projected experience under the federal Act without the mandate. Thus, while some States saw "skyrocketing premiums" as a consequence of adverse selection, *see* Texas Public Policy Foundation Amicus Br. 28 (discussing Washington), none of the estimates of premium increases under the Act without the minimum coverage provision contemplate that kind of dramatic change. Indeed, as we have noted, one study described the likely effects of adverse selection on premium rates as "much lower than might be expected." Sheils & Haught: *Without the Individual Mandate*, at 7.

The possible reasons for the differences in outcome, real and projected, are not hard to fathom. As far as we can tell, no State providing for guaranteed issue and community rating bolstered its insurance reforms with subsidies of the particular type and magnitude contemplated by the federal Act. *See, e.g.*, Buettgens & Carroll: *Eliminating the Individual Mandate*, at 1 ("New York does not have the provision under the ACA that provides subsidized coverage in the exchanges"). Yet, both the amount of the subsidies and their particular structure – which essentially shelters subsidized purchasers from premium increases that might otherwise result from adverse selection – play an important role in assuring that younger and healthier people become part of the insurance pool. An insurance program that does not mirror those incentives cannot expect the same results.

There are also differences between rules that are limited to a single State and rules that operate nationwide. For example, the United States says that, after implementing its plan with guaranteed issue and community rating, the State of Washington attracted sick people from other States who were seeking immediate coverage, resulting in rapidly increasing premiums. *See* US Br. 48-49. But, even leaving aside the fact that the federal Act allows for the imposition of limited annual enrollment periods, uniform requirements of guaranteed issue and community rating throughout the country would forestall migration that might occur under a varying state-by-state system where consumers could move from States that do not have such requirements to States that do. And States are free, under the Act, to establish multi-State Exchanges if they so desire. *See* 42 U.S.C.A. § 18054.

In any event, even if the States' experience were regarded as a reliable benchmark for what might be expected under the Act, it would still not prove the point that petitioners and the United States are trying to make: that Congress would prefer to have no guaranteed issue and community rating requirements, rather than have them without a minimum coverage provision. If that assumption were correct, one would expect history to show that, having observed the consequences of their laws, all the States either added a minimum coverage provision or repealed their guaranteed coverage and community rating provisions. But that is not what happened. A few States did end the requirements of guaranteed coverage and community rating, but other States left their systems largely in place or made relatively modest changes to lessen the effects of adverse selection. Only Massachusetts enacted a mandate.

In the end, therefore, four of the cited States (Maine, New Jersey, New York, and Vermont) have continued to operate health care systems with guaranteed issue and community rating but no requirement to purchase insurance, although Vermont has provided for higher deductibles and allowed insurance companies to impose waiting periods before coverage takes effect. *See* Kaiser Family Foundation, *Individual Market Guaranteed Issue* (statehealthfacts.org/comparetable.jsp?ind=353&cat=7); *Individual Market Rate Restrictions* (statehealthfacts.org/comparetable.jsp?ind=354&cat=7). *See also* Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, at 5-46 (2007) (reviewing state laws). Washington has amended its law to allow for longer waiting periods and the exclusion of particularly high-risk applicants (who are placed in a separate high risk pool). *See* Governor of Washington Amicus Br. 12. But only New Hampshire and Kentucky have done what petitioners and the United States urge the Court to do here: eliminate guaranteed issue and community rating completely. Thus, despite premium increases considerably greater than might be expected under the federal Act, legislatures in a number of reform States have apparently decided that the benefits of guaranteed issue and community rating remain worth having. Indeed, a former Governor of Vermont has expressed his view, based on the experience in that State, that "an individual mandate is not essential either to achieve near universality or to have a stable insurance market." Howard Dean, *Health Care Reform Will Succeed Without Individual Mandate*, at 2 (Huffington Post, January 13, 2012).

E. Elimination of the guaranteed issue and community rating provisions would also interfere with operation of the new insurance exchanges. Yet, establishment of those exchanges was unquestionably an important objective of federal health care reform. Through the Act, Congress sought to create a central marketplace where individuals and small businesses (and, perhaps, large businesses) could shop for, and purchase, health insurance. As envisioned, the Act "would make purchasing health insurance easier and more understandable by creating state-based web portals, or 'exchanges,' that would direct consumers to all available health plan options." S. Rep. No. 89, 111th Cong., 1st Sess., at 4 (2009) (discussing S. 1796).

A critical feature of those exchanges, however, was the greater standardization of health insurance policies. Rather than having health insurance companies continue to offer the complex, multi-factored policies that often issued under the prevailing system of individual underwriting – with frequent exclusions for pre-existing conditions and widely varying premium charges – greater standardization of policies would "force insurance companies to compete on price and quality and not their ability to select the healthiest individuals and [would] ensure[ ] that every policy offered in the individual and small group market provides meaningful coverage for essential services." *Id.* at 4. In turn, information about health care policies would become more uniform and accessible. "The exchanges would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials." *Id.*

Those basic goals would be significantly frustrated by invalidation of the guaranteed issue and community rating provisions. As conceived, the Act would lead to easily comparable policies precisely because the policies would cover similar services and, with only a few exceptions, would not vary according to the individual characteristics of the insured. Elimination of the guaranteed issue and community rating provisions, by contrast, would reinstate medical underwriting, where insurance companies can tailor their policies to reduce the risk presented by a particular insured's anticipated health care costs. Although the exchanges could still serve in some fashion as a central marketplace, the lack of standardized products would make comparisons difficult for many consumers, thus undermining much of what Congress hoped to achieve.

Petitioners argue that the close connection between the exchange provisions, on the one hand, and the guaranteed issue and community rating provisions, on the other, is proof that Congress would want all of those provisions struck down along with the minimum coverage provision. *See* States Br. 47-50; NFIB Br. 46-47. But we think that petitioners are drawing the wrong conclusion. Because the effects of invalidating the guaranteed issue and community rating provisions could not easily be limited to just those provisions, the potential spillover effect makes it even less likely that Congress would intend for them to be deemed inseverable. In that case, the consequences would not be just the denial of insurance to many people with the greatest need for it, but disruption of the new insurance marketplace, thus weakening two of the Act's central reforms.

Taken as a whole, therefore, the evidence does not establish that the Court should take the extraordinary step of striking down the guaranteed issue and community rating provisions. Although the United States asserts that "enforcement of those provisions without a minimum coverage provision would *restrict* the availability of health insurance and make it *less* affordable," US Br. 45, that broad claim overlooks the fact that, for many people faced with high health care costs as a result of pre-existing illnesses or other risk-related factors, the expense of obtaining insurance under the Act, even without the minimum coverage provision, will be much lower than under the system that Congress was seeking to replace. Thus, while Congress undoubtedly intended the minimum coverage provision to play a role in controlling insurance prices, if that option is taken off the board, it cannot be said with the necessary degree of confidence that Congress would prefer "no law at all." *Free Enterprise Fund*, 130 S.Ct at 3161. The guaranteed issue and community rating provisions thus should stand.

IV. THE REMAINDER OF THE ACT SHOULD BE LEFT INTACT

Petitioners do not make an independent argument that all other provisions of the Act should be invalidated even if the guaranteed issue and community rating provisions continue in force. Apart from their severability clause theory, *see* pages 29-31 *supra*, petitioners' argument for invalidating the Act in its entirety depends upon a chain of accumulating inseverability, beginning with the minimum coverage provision and proceeding through the guaranteed issue and community rating provisions as well as the exchange provisions, until it reaches an undefined point at which Congress supposedly would not regard the rest of the Act as sufficient to exist on its own. As we have just explained, however, the process of invalidation properly stops, once and for all, with the minimum coverage provision. So, under that theory, the rest of the Act should stand, not fall.

In any event, the United States persuasively explains why elimination of the minimum coverage provision does not justify striking down the Act as a whole. *See* US Br. 28-40. Compared to the guaranteed issue and community rating requirements, the remainder of the Act has far less connection to the minimum coverage provision – in many instances, none whatsoever – and petitioners have made little attempt to demonstrate that the Act in general, or specific provisions in particular, cannot function in an effective manner without the minimum coverage provision alone. That shortage of proof is enough to foreclose any further invalidation. And, even if it were not, it is apparent that many important parts of the Act can operate quite well without the minimum coverage provision.

Two examples will illustrate the point. First of all, a significant portion of the Act was designed to address the fact that many uninsured people have low incomes but are nevertheless ineligible for Medicaid. As a Kaiser Family Foundation report explained, Medicaid and the Children's Health Insurance Program (CHIP) primarily cover "four main categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities." Kaiser Family Foundation, *The Uninsured: A Primer*, at 4. "Individuals who do not fall into one of these groups – most notably adults without dependent children – are now generally ineligible for public coverage regardless of their income." *Id.* Indeed, "adults without dependent children comprise the majority of the uninsured largely because they are the least likely to qualify for Medicaid . . . ." *Id.*

The Act deals with this problem by, among other things, expanding the criteria for Medicaid eligibility. Under the new provisions, which are scheduled to take effect in 2014, Medicaid coverage will effectively be available to those with incomes at or below 138 percent of the Federal Poverty Line. *See id.* (In 2011, the Federal Poverty Line was $10,890 for an individual and $22,350 for a family of four). Various estimates indicate that these changes to Medicaid will result in substantial enrollment increases even without a mandate. For example, the CBO projects that Medicaid enrollment will increase by approximately 10 million people by 2017 without the minimum coverage provision in effect. *See* Cong. Budget Office, *Estimated Effects of the Insurance Coverage Provisions of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate*, Table 4 (March 20, 2010) (Medicaid enrollment would increase by 16 million in 2017 with the mandate); CBO, *Effects of Eliminating the Individual Mandate*, at 2 (compared to the Act with the mandate, "about 6-7 million fewer individuals with Medicaid or CHIP coverage"). The January 2012 Urban Institute study estimates that coverage would increase by 12.9 to 13.9 million people without a mandate, Buettgens & Carroll: *Eliminating the Individual Mandate*, at 3 (Table 1), while the Lewin Group study estimates that there would be an increase of 13.4 million people without the minimum coverage provision. Sheils & Haught: *Without the Individual Mandate*, at 6 (Exhibit 2). Of course, invalidation of the minimum coverage provision would mean that enrollment in

Medicaid would be voluntary – thus accounting for the lower numbers of new enrollees without it – but that is no reason to deny Medicaid coverage to the 10 million or more people who want to have it.[12]

The provisions with respect to employer-provided insurance also can operate effectively in the absence of the minimum coverage provision, provided that the guaranteed issue and community rating provisions (and the exchanges) remain in place. Although employer-subsidized insurance has long been a central feature of the health insurance market, the availability of employer-subsidized insurance is not uniform among large and small businesses. *See* Kaiser Family Foundation: *The Uninsured: A Primer*, at 17-18 ("[n]early all businesses (99%) with at least 200 workers offer health benefits to their workers in 2011, but only 59% of firms with less than 200 workers offer these benefits"). To build upon the existing system, therefore, the Act made several changes. For the largest firms (at least 200 full-time employees), which overwhelmingly offer insurance to their workers anyway, the Act requires automatic enrollment of workers to increase the already high rate of acceptance. *See* 29 U.S.C.A. § 218a. For large employers (at least 50 full-time employees), the Act provides penalties for firms that do not offer adequate health insurance plans and that have at least one employee purchasing subsidized insurance through an exchange. *See* 26 U.S.C.A. § 4980H(a). Finally, for small employers (fewer than 25 full-time employees), the Act establishes a program of employer subsidies to encourage them to offer insurance. *See* 26 U.S.C.A. § 45R.

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[12] Expanded Medicaid eligibility is intended to work in concert with the premium subsidies discussed earlier, which can also function without the minimum coverage provision. *See* US Br. 36.

The minimum coverage provision was undoubtedly intended to increase the effectiveness of this modified employer-based insurance system, but its absence, again, does not mean that Congress would have chosen to forego the reforms entirely. One study estimates that, even without a mandate, the percentage of workers at firms offering insurance would increase from 84.6 percent to 92.7 percent, with especially large increases in firms with 10 or fewer workers (45.3 percent to 70.1 percent) and firms with between 11 and 25 workers (62.6 percent to 85.7 percent). *See* Christine Eibner et al., ***Establishing State Health Insurance Exchanges***, at 19 (Table 3.3) (status quo figures), 25 (Table 3.11, Column 7) (Rand 2010). Although the number would be still greater with the minimum coverage provision in effect, *see id.* at 25 (Table 3.11, Column 1), the substantial increase in workers at firms offering health insurance would nevertheless be a significant step towards achievement of Congress's goals. As with Medicaid, therefore, it is doubtful that Congress would want the Court to nullify its attempts to bolster employer-sponsored insurance, simply because the gains would be less than expected under the full Act.

Finally, we submit that, insofar as the rest of the wide-ranging Act is concerned, the usual judicial reluctance to find inseverability should be at its strongest when the question is whether to strike down provisions – such as one, noted by the district court, requiring employers to provide a separate room for nursing mothers (*see* US Pet. App. 353a; 29 U.S.C.A. § 207(r)(1) – that have no apparent connection at all, let alone an inextricably close connection, to the minimum coverage provision. To be sure, the district court did strike down the entire Act, including the nursing mother provision, but it did so in part on the ground that Congress had intended to make the entire Act inseverable by removing a severability clause, a rationale that, while incorrect, at least offers a coherent basis for invalidating provisions that are totally unrelated to the minimum coverage provision. *See* US Pet. App. 354a-356a. Apart from that rationale, however, it is difficult to see any reasonable justification for striking down completely separate statutory provisions. And, that description fits most of the Act.

All in all, therefore, petitioners and the United States have not demonstrated that any of the Act's lawful provisions should be declared unenforceable. The Court can remedy the unconstitutionality of the minimum coverage provision by severing that provision from the remainder of the statute, providing full redress to the plaintiffs while "maintain[ing] the act in so far as it is valid." *Alaska Airlines*, 480 U.S. at 684 (internal quotation marks omitted). Having "limit[ed] the solution to the problem," *Free Enterprise Fund*, 130 S. Ct. at 3161, the Court should decline to go any further.

CONCLUSION

If the Court determines that the minimum coverage provision is unconstitutional, the judgment of the Court of Appeals for the Eleventh Circuit that the provision is severable from the remainder of the Patient Protection and Affordable Care Act should be affirmed.

Respectfully submitted,

H. BARTOW FARR, III
Counsel of Record
FARR & TARANTO
1150 18th Street, N.W.
Suite 1030
Washington, DC 20036
(202) 775-0184
farrandtaranto@aol.com

February 17, 2012

AMICUS
CURIAE
BRIEF

No. 11-400

IN THE

Supreme Court of the United States

STATE OF FLORIDA, *et al.*,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICUS CURIAE* THE DISABILITY RIGHTS LEGAL CENTER IN SUPPORT OF RESPONDENTS AND IN FAVOR OF AFFIRMING THE CONSTITUTIONALITY OF THE MEDICAID EXPANSION PROVISIONS OF THE AFFORDABLE CARE ACT

PAULA D. PEARLMAN
SHAWN KRAVICH
CANCER LEGAL RESOURCE CENTER OF THE DISABILITY RIGHTS LEGAL CENTER
800 S. Figueroa Street
Suite 1120
Los Angeles, CA 90017
(866) 843-2572

CHRIS M. AMANTEA
Counsel of Record
DOUGLAS M. MANCINO
IAN T. MAHER
ALAN M. WITLEN
HUNTON & WILLIAMS LLP
550 S. Hope Street, Suite 2000
Los Angeles, CA 90071
camantea@hunton.com
(213) 532-2000
Counsel for Amici Curiae

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INTEREST OF *AMICUS CURIAE*

The Disability Rights Legal Center (DRLC) is a non-profit organization dedicated to championing the rights of people with disabilities through education, advocacy, and litigation. DRLC accomplishes its mission through many programs, including the Cancer Legal Resource Center (a joint program with Loyola Law School, Los Angeles), the Education Advocacy Program, the Community Advocacy and Outreach Programs, and the Civil Rights Litigation Program. Since 1975, DRLC has handled countless disability rights cases under state and federal civil rights laws challenging discriminatory practices by government, business, and educational institutions.

A central tenet to championing the rights of people with disabilities includes the promotion of access to adequate, affordable healthcare for those with any kind of health condition, including people with pre-existing conditions such as cancer. DRLC has a particular interest in cancer-related legal issues through its national Cancer Legal Resource Center (CLRC) program. The CLRC provides free information and resources on cancer-related legal issues such as access to government benefits and health care, employment and taking time off work, insurance coverage, and estate planning to cancer patients, survivors, caregivers, health care professionals, employers, and others coping with cancer nationwide.

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[1] Pursuant to Rule 37.6, *amicus* affirms that no counsel for a party authored this brief in whole or in part and that no person other than *amicus* and its counsel made a monetary contribution to its preparation or submission.

From the CLRC's direct work with populations affected by cancer, the CLRC understands that access to government benefits such as Medicaid is an area of primary concern to people with cancer and their families. The onset of cancer is most often unexpected: many people learn of their cancer diagnosis when uninsured or underinsured. In 2012 alone, approximately 577,190 Americans are expected to die from cancer, which amounts to 1,500 deaths a day. *Cancer Facts & Figures 2012*, AMERICAN CANCER SOCIETY, at 1 (2012), http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf. Indeed, 137,000 adults ages 25 to 64 died because of a lack of health insurance from 2000 through 2006. Stan Dorn, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*, URBAN INSTITUTE, at 2 (Jan. 2008). The high cost of private insurance and limited opportunities for low-income people seeking affordable alternatives lead to a high population of uninsured or underinsured individuals, many of whom may miss out on life-saving opportunities for preventative care before diseases advance to uncontrolled limits.

Though the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119, as amended by the Health Care and Education and Reconciliation Act, 111-152, 124 Stat. 1029 (collectively the "Affordable Care Act," "ACA," or the "Act") significantly expanded opportunities for all people, including people with disabilities, to access healthcare, the Affordable Care Act would fall short of providing access to millions of individuals—many of whom are people with disabilities—if not for the comprehensive Medicaid expansion that the Affordable Care Act contemplates. For many, Medicaid coverage will enable new diagnoses and treatments of cancer and other chronic conditions early on—decreasing cost and complication from late diagnosis and increasing survivorship. Accordingly, the DRLC strongly supports the Congressional expansion of Medicaid eligibility under the Affordable Care Act.

SUMMARY OF ARGUMENT

The Cancer Legal Resource Center is a program of the Disability Rights Legal Center with specialized knowledge of healthcare access for people with cancer. As such, cancer will be used as an example to illustrate the experience of people with all types of chronic illness. However, cancer is just one of multiple chronic diseases that have the potential to effectively be combated by Medicaid expansion pursuant to the Affordable Care Act.

Expansion of Medicaid under the ACA will allow lower income uninsured individuals to have access to preventative medical services that will lower long-term healthcare costs of state and local governments. When serious health conditions such as cancer are caught early, treatment options generally become shorter and less expensive. Moreover, costs associated with emergency room services are reduced because individuals who have health insurance are able to be proactive about screening and early detection and are more likely to seek treatment before a medical emergency arises. Further, earlier detection and treatment will increase the overall rate of survivorship of diseases like cancer.

Cancer is the second leading cause of death in the United States where an estimated one in four people in the country will die from this disease. *Cancer Facts & Figures 2012*, AMERICAN CANCER SOCIETY, at 1 (2012), http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf. Many of these deaths could have possibly been prevented with more routine screenings for cancer, especially for those who are currently uninsured.

Aside from the financial savings related to an expanded Medicaid program, if any of these deaths can be prevented, then Congress has rationally and reasonably exercised its Spending Clause powers for this social benefit alone. It is well-established that, incident to that power, Congress has the authority to attach conditions to the receipt of federal funds for purposes of achieving certain policy objectives, including those that Congress could not otherwise satisfy through direct regulation. *See, e.g., Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980) ("Congress is empowered to 'further broad policy objectives by conditioning the receipt of federal monies upon compliance by the recipient with federal statutory and administrative directives.'").

ARGUMENT

Since its inception in 1965, Medicaid has focused on providing healthcare coverage to low income people who are blind, who have disabilities, or who are 65 or over. Changing Medicaid to include all non-elderly individuals with incomes below 138 percent of the federal poverty level represents a social safety net to provide healthcare services for low income individuals.

While the states are focused on what is perceived to be increased costs for the provision of medical coverage through the Affordable Care Act, ultimately medical costs to the states will be reduced with preventative care that will become available under the Act. Thus, rather than a coercive expansion of Medicaid, the Act will likely result in cost savings by preventing emergency room visits, identifying and treating conditions at an earlier and less costly stage for treatment, or otherwise employing recognized preventative care and cost reduction practices that reduce long-term spending and expensive treatments. Many of these expensive treatments and costs associated with acute untreated illness and diseases such as cancer are already borne by state and local governments through government-funded emergency rooms and hospitals that serve the uninsured. These costs and services are currently being provided without direct federal government reimbursement. The Act's Medicaid funding provision will cover services that are already being provided by the states. Moreover, it does this in a way that will ultimately reduce long-term costs on states.

POLICY ARGUMENTS FAVOR MEDICAID EXPANSION PROVIDED FOR BY THE AFFORDABLE CARE ACT

On March 23, 2010, the Affordable Care Act was enacted into law. Title II of the Affordable Care Act addresses the role of public programs, and establishes a detailed and much needed program for expanded access to Medicaid. To be sure, the Medicaid program is the cornerstone for the Government's expanded health care coverage.

A. Medicaid Expansion Will Address the Uninsured Medical Coverage Epidemic in the United States

The number of people uninsured for medical coverage in the United States has reached epidemic proportions. According to the last census, over 50 million people (spread across every income bracket) currently have no medical coverage. *Florida v. United States Dep't of Health & Human Servs.*, 648 F.3d 1235, 1248 (11th Cir. 2011) (citing U.S. Census Bureau, P60–238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, at 23 tbl.8 (2010), *available at* http://www.census.gov/prod/2010pubs/p60-238.pdf.). Many of these individuals either do not seek medical coverage at all or are denied access to much-needed medical services, including preventative care. *Id.* at 1247. The ACA expands Medicaid eligibility and provides significant Medicaid subsidies to those who most need it.

Indeed, "[a]s a result of the act's Medicaid expansion, an estimated 9 million of the 50 million currently uninsured will be covered for health care by 2014 (and 16 million by 2016 and 17 million by 2021)." *Id.* at 1263. Additionally, states will only pay a small percentage of the increased cost associated with the expansion. *Id.* at 1267-68 ("the states will only have to pay incidental administrative costs associated with the expansion until 2016; after which, they will bear an increasing percentage of the cost, capping at 10% in 2020.").

B. The Economic Costs Associated with Cancer and Other Chronic Illnesses are Great but can be Reduced by Preventative Screening

According to the National Institute of Health, the overall costs of cancer in 2007 amounted to $226.8 billion. *Cancer Facts & Figures 2012*, AMERICAN CANCER SOCIETY, at 3 (2012), http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf. Costs will only increase in the future due to an increasingly growing and aging population. In fact, trends show that by 2050, the number of new cancer patients is expected to double to 2.6 million people. *Id.* at 33. As the second leading cause of death in the United States, cancer represents a significant source of financial and social cost to this country. *Id.* at 1.

Even among these tragic numbers, there are certain socioeconomic groups that are hit harder than others. People with a lower socio-economic status represent a disproportionate number of cancer deaths. For example, a recent study showed that the mortality rate for African-American and white men who had 12 or fewer years of education was more than three times higher than that of college graduates. *Id.* at 43. While this higher mortality rate may be attributed to activities that increase one's risk of developing cancer such as smoking or having a poor diet, it is also the result of higher barriers to healthcare among lower income individuals.

Uninsured individuals are more likely than insured individuals to only seek medical intervention when faced with an emergency. They tend not to seek preventative care or will not put as much effort into managing chronic health conditions. *Cancer Facts & Figures 2008*, AMERICAN CANCER SOCIETY, at 29 (2008), http://www.cancer.org/acs/groups/content/@nho/documents/document/2008cafffinalsecuredpdf.pdf. Cancer, in particular, is a disease whose treatment plan and prognosis can vary widely according to what stage it is detected. A cancer's stage is determined by the primary tumor's size and whether the cancer has spread to other areas of the body. *Cancer Facts & Figures 2012*, AMERICAN CANCER SOCIETY, at 2 (2012), http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-031941.pdf.

Regular screening for cancer can result in early detection and removal of cancerous growths when the disease is the most treatable and when the chance of survival is highest. The types of cancer that can be detected early through screening, which account for at least half of all new cancer cases, include breast, colon, rectal, cervical, prostate, oral cavity, and skin cancer. *Id.* at 1. Many of these types of cancer can be screened by general practitioners; accordingly, as Medicaid expansion provides otherwise unavailable opportunities for health care access, patients are increasingly more likely to get access to life-saving information when it can help them the most. There are also significant cost reduction benefits to early screening and detection as well. Indeed, survivorship aside, no study is required to demonstrate the medical cost differences between the preventative removal of a pre-cancerous skin legion—a standard out-patient procedure—and the intensive chemotherapy and radiation treatments of stage-four melanoma.

Despite widespread knowledge that early detection is key in the treatment of cancer, studies have repeatedly found that compared to those who have Medicaid or private health insurance, individuals without insurance are less likely to get screenings for cervical, breast, and colorectal cancer. *Cancer Facts & Figures 2008*, AMERICAN CANCER SOCIETY, at 30 (2008), http://www.cancer.org/acs/groups/content/@nho/documents/document/2008caffinalsecuredpdf.pdf. For example, according to a study conducted in 2005 by the National Health Interview Survey (NHIS), 74.5 percent of women with private insurance and 56.1 percent of women on Medicaid had a mammogram in the past two years. *Id.* By contrast, only 38.1 percent of uninsured women had a mammogram in that same time period. *Id.* The biggest reasons for not seeking this type of preventative care are cost and the lack of access to affordable healthcare. *Id.* at 29. Both of these impacts are mitigated by the Medicaid expansion provisions of the ACA.

CONCLUSION

We urge the Court to consider the ultimate cost savings attributed to preventative care and early treatment, as well as funding for treatment that would flow to the states, and to affirm the decision below and uphold the constitutionality of the Affordable Care Act.

Respectfully submitted,

PAULA D. PEARLMAN
SHAWN KRAVICH
CANCER LEGAL RESOURCE
CENTER OF THE DISABILITY RIGHTS LEGAL
CENTER
800 S. Figueroa Street
Suite 1120
Los Angeles, CA 90017
(866) 843-2572

February 17, 2012

CHRIS M. AMANTEA
Counsel of Record
DOUGLAS M. MANCINO
IAN T. MAHER
ALAN M. WITLEN
HUNTON & WILLIAMS LLP
550 S. Hope Street
Suite 2000
Los Angeles, CA 90071
camantea@hunton.com
(213) 532-2000
Counsel for Amici Curiae

AMICUS
CURIAE
BRIEF

No. 11-400

IN THE

Supreme Court of the United States

STATE OF FLORIDA, *ET AL.*,
Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR *AMICI CURIAE* ECONOMISTS IN SUPPORT OF STATE PETITIONERS REGARDING MEDICAID EXPANSION

STEVEN G. BRADBURY
STEVEN A. ENGEL*
MICHAEL H. PARK
ELISA T. WIYGUL
DECHERT LLP
1775 I Street, NW
Washington, DC 20006
(202) 261-3300
steven.engel@dechert.com

**Counsel of Record*

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INTEREST OF THE *AMICI CURIAE*[1]

Amici Curiae are 101 economists who have studied, researched, and participated in the national policy discussion relating to the healthcare markets. *Amici* include Nobel laureates, former senior government officials, and faculty from research universities around the country. *Amici* support the need for reform but believe that the Affordable Care Act ("ACA" or the "Act") will likely exacerbate, rather than constrain, the inflation in healthcare costs that poses a serious long-term challenge to the U.S. economy. A complete list of *amici* can be found in the Appendix, beginning on page 1a.

Most of *amici* previously filed a brief with the Court of Appeals for the Eleventh Circuit addressing the economic premises on which the Government relied in seeking to defend the ACA's individual mandate as a regulation of interstate commerce. The Eleventh Circuit expressly relied upon *amici*'s analysis in finding the mandate unconstitutional. *See Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1299 & nn.108-111, 113 (11th Cir. 2011).

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[1] No counsel for any party has authored this brief in whole or in part. Several of *amici curiae* are affiliated with the American Action Forum ("AAF"), an independent and nonpartisan research institution, and AAF has made a monetary contribution to the preparation and submission of the brief. Save for AAF, no person other than *amici* or their counsel has made a monetary contribution to the preparation or submission of this brief. *See* Sup. Ct. R. 37.6. All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk of this Court.

Before this Court, most of *amici* filed a brief in support of Petitioners on the severability question. *Amici* also intend to file a brief addressing the economic issues relating to the constitutionality of the individual mandate, according to the schedule this Court has ordered.

Amici submit this brief in support of the State Petitioners' position that the Medicaid expansion provisions of the Act unconstitutionally coerce the States by threatening a loss of all federal Medicaid funds if a State does not accept the Act's considerable expansion of Medicaid eligibility. *Amici* seek to assist the Court in understanding the concrete effects that declining federal Medicaid funding would have on States' budgets. As those numbers make clear, the States are left with no realistic choice but to accept the new conditions Congress has imposed on them.

SUMMARY OF ARGUMENT

An expenditure of federal funds is unconstitutional when it coerces rather than merely encourages States to enact a federal policy. To have any substance, this anti-coercion principle of federalism must mean that a federal statute must preserve for the States a real, and not merely a theoretical, choice between adopting Congress's policy preferences and forgoing the funds that Congress has tied to compliance. As more than 20 percent of all state spending from any source, Medicaid is a major part of state budgets. Under the ACA, Congress has taken the dramatic step of transforming Medicaid from a program designed to provide assistance to the impoverished and special needs groups, such as the disabled, into a mandatory federal entitlement – effectively obligatory on both the States and beneficiaries alike – that reaches even working adults whose incomes fall well above the poverty level. States that do not accept the substantial expansion of eligibility, elimination in flexibility, and other reforms will lose *all* federal Medicaid funds and indeed will no longer be running a Medicaid program at all.

To quantify the effect of such a major fiscal loss and to test whether States could realistically choose to decline Congress's offer, *amici* analyzed public data from governmental sources to compare federal Medicaid spending to the current magnitude of States' budgets, tax collection, and population. *See* Appendix at 10a-11a.

These data confirm and quantify what is already clear from the many declarations submitted by the States Petitioners to the district court in support of summary judgment: The States are in no realistic position to fill the enormous gap that the loss of federal Medicaid funding would leave. If the States suddenly were forced to add 2009 federal Medicaid expenditures to their total 2009 state budgets (excluding federal funds and bonds), the States' total budgetary expenditures would jump by 22.5 percent. Expressed another way, federal Medicaid spending represents an even more imposing 34.4 percent of taxes collected by the States nationwide. The States are not in any position to forgo federal funds and turn to their own means of raising revenue or cutting other spending to fill the gap.

Nor are the States in a position simply to drop Medicaid coverage and allow their neediest residents to fend for themselves. The social, not to say political, costs of such a drastic change in the safety net of a State would plainly be unacceptable. Even if a State were to take the drastic measure of declining federal funds and refusing to set up an alternative Medicaid-like program, that State's healthcare providers would still be subject to federal mandates requiring them to provide emergency stabilization care to all, regardless of ability to pay. If any State withdrew from Medicaid and did not seek to provide subsidies to its healthcare providers to match the rise in uncompensated care, many providers in that State would simply be unable to sustain those costs and would go out of business.

While Congress's decision to compel Americans to purchase health insurance was the ground upon which the Court of Appeals held the ACA's individual mandate to be unconstitutional, this Court should not overlook an equally important constitutional limitation trampled by the Act. The States, as co-equal sovereigns in our Nation's constitutional scheme, may not be compelled to adopt the policy preferences of the federal government. Congress's decision to tie a State's entire federal Medicaid funding to the State's endorsement of the ACA's dramatic expansion of Medicaid is manifestly coercive and thus unconstitutional.

ARGUMENT

THE ACA'S EXPANSION OF MEDICAID LEAVES STATES WITH NO ECONOMICALLY FEASIBLE CHOICE OTHER THAN TO ACCEDE TO FEDERAL COERCION

The ACA's Medicaid expansion provisions, ACA §§ 2001, 2002, 42 U.S.C. § 1396a, impose on the States a vast enlargement of the federal-state public healthcare program. Rather than provide the States with a choice as to whether to adopt, and to fund in part, this expansion, the price of a State's refusal is the loss of all existing federal Medicaid contributions.

These provisions plainly impose an unconstitutional condition of federal spending by coercing the States into accepting and participating in the federal government's enormously expanded program because the States could only "in theory," not "in fact," opt to forgo receipt of all federal Medicaid contributions. *South Dakota v. Dole*, 483 U.S. 203, 211, 212 (1987). As *Dole*'s analysis makes clear, in determining what is unconstitutionally coercive the focus must be on "the financial inducement offered by Congress" – specifically the magnitude of the loss that the States would sustain if they declined to comply. *Id.* at 211; *see also* Pet. Br. (Medicaid) at 46-47. Where, as here, the alternative of turning down Congress's new conditions would be fiscally devastating to the States, the States have no meaningful choice but to acquiesce. The federal government's imposition of such overbearing and coercive conditions on the exercise of state policy goes well beyond what is permitted by our Constitution's system of federalism.

A. States Could Not Realistically Turn Down Federal Medicaid Funding While Maintaining Their Existing Levels Of Medicaid Coverage

In an attempt to quantify the devastating economic effect on States of losing all federal Medicaid funds, *amici* have drawn upon data from publicly available governmental sources – the U.S. Census Bureau, the Centers for Medicare and Medicaid Services, and the National Association of State Budget Officers – to compare the federal Medicaid funds that each State receives to that State's expenditures and tax collections.[2] By law, the federal government commits to contribute between 50 and 83 percent of each State's total Medicaid expenditures. 42 U.S.C. § 1396d(b). As of 2009, federal dollars amounted to roughly two-thirds of all Medicaid expenditures nationwide. *See* Appendix at 11a. Given that Medicaid is a substantial part of every State's total budgetary expenditures, it should thus come as no surprise that the loss of federal Medicaid funds would have a catastrophic effect on States' fiscal wellbeing.

Amici's analysis of the publicly available data shows that if a State were to forgo federal Medicaid funding while retaining the same level of coverage for its citizens, then the State's fiscal picture would become unrecognizable. For instance, on a nationwide basis, federal Medicaid spending is the equivalent of one-third of *all* state tax collection. Six States, moreover, would have to come up with more than 50 percent of their current tax revenue in order to make up for the lack of federal Medicaid funding. For well over half of the States, this figure would exceed 25 percent.[3] Put another way, the federal government expends an average of $778 dollars per year on Medicaid for every state resident, and that figure is more than $1,000 per resident in nine States. *See* Appendix at 10a-11a.

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[2] *Amici* used data from fiscal year 2009, the most recent year for which State-by-State Medicaid data were available in sufficient detail. *Amici* drew the Medicaid and population data used in their analysis from Centers for Medicare and Medicaid Services ("CMS"), *Medicaid Enrollment by State*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html (follow hyperlinks to individual States' data) (last visited Jan. 16, 2012) (providing Medicaid data from CMS and population data from the U.S. Census Bureau). For *amici*'s state tax collection data, see U.S. Census Bureau, *State Government Tax Collections: 2009*, http://www2.census.gov/govs/statetax/09staxss.xls. For *amici*'s state budget data, see National Association of State Budget Officers, *Fiscal Year 2010 State Expenditure Report: Examining Fiscal 2009-2011 State Spending* 7 (2011), http://nasbo.org/LinkClick.aspx?fileticket=C3LJlSFxbdo%3d&tabid=79. *Amici* drew from this source figures for fiscal year 2009 total state expenditures minus federal funds and funds from bonds, which are from previously issued bonds and therefore are not a source of potential new funding. *Amici*'s complete findings are set forth in the Appendix beginning at page 10a.

While States certainly have more than one means to raise revenue or cut spending, it is clear that an abrupt 50 percent or even 33 percent increase in state taxes across the board would be politically impossible. Such measures also would be economically infeasible, given the practical limits on States' borrowing ability, as well as the power of both labor and capital within a State to vote with their feet, in the event that one State's tax burden becomes too onerous as compared to its neighbors'.

Furthermore, a State's current federal Medicaid funding, if anything, underestimates the costs that a State that turned down federal Medicaid funds would incur in order to maintain current Medicaid coverage levels. As the State Petitioners have pointed out, such a State would incur substantial start-up costs to create an alternative Medicaid-like, State-only program. *See* Pet. Br. (Medicaid) at 45. Similarly, a State that withdrew from Medicaid might lose other federal funds, such as Temporary Assistance for Needy Families, which is premised on the expectation that States will participate in Medicaid. *See id.* at 11; *see also* Decl. of Deborah K. Bowman, Sec'y, Dep't of Soc. Servs., S.D., at JA 175-76 ¶ 16 (explaining that "[t]hough theoretically possible, South Dakota cannot cease participation in the Medicaid Program" because if it lost federal funds, including those recently provided by the American Recovery and Reinvestment Act, it "would be required to expend 75.58% of its total state general fund budget" to maintain the same levels of Medicaid coverage).[4] Medicaid has thus become an entrenched part of States' ability to meet their many budgetary commitments. Putting aside the fact that many States already are having historic difficulty in meeting their current budgetary commitments, there is no practical way in which a State could maintain its current level of Medicaid coverage while declining federal funds.

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[3] The States whose total tax collections are less than twice what the federal government gives that State in Medicaid funds are Arizona, Maine, Mississippi, Missouri, New Mexico, and Tennessee. Federal Medicaid expenditures exceed one-third of state tax collections in an additional 17 States and exceed one-quarter of state tax collections in an additional 13 States. *See* Appendix at 10a-11a.

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[4] While the district court took Ms. Bowman's declaration as a concession that South Dakota could "cease participation in the Medicaid Program," *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1268 (N.D. Fla. 2011), the exact opposite is true. Short of *explicit* commandeering like that this Court struck down in *New York v. United States*, 505 U.S. 144, 175-76 (1992), declining Congress's spending inducements is always "theoretically possible." This Court has made clear, however, that the relevant question is whether opting out is practical in reality. *See, e.g., Dole*, 483 U.S. at 211-12.

B. States Could Not Realistically Turn Down Federal Medicaid Funding Without Providing Some Alternative Healthcare Funding For Low-Income State Citizens

Equally unthinkable would be dropping all Medicaid-like coverage. The Government has not seriously contested the numerous declarations that the State Petitioners have submitted attesting to the unsurprising conclusion that a loss of public health insurance for States' most vulnerable populations would create nothing short of a "health care emergency affecting its poorest and neediest citizens." Decl. of Elizabeth Dudek, Interim Sec'y, Agency for Health Care Admin., Fla., at JA 81 ¶ 33 (citing "severe health repercussions, including possible loss of life").

If a State did not offer a Medicaid-like program, the State would experience a profound crisis in both the health of its neediest citizens and the finances of its healthcare providers because the absence of Medicaid would lead to a massive increase in uncompensated health care provided to former Medicaid recipients. As noted, federal funds constitute two-thirds of Medicaid spending nationwide, and more than 80 percent of some States' Medicaid spending. *See* Appendix at 10a-11a. Any State that attempted to set up a new program without expending any more state funds than it currently expends would be forced to make very deep cuts in services, even before factoring in the start-up costs of establishing such an alternative program.

Even leaving aside the extreme human cost of such cuts, States could not avoid significant outlays to prevent their healthcare systems from plunging into crisis. As the Government notes elsewhere in support of the ACA's individual mandate, various laws require providers to care for patients under some circumstances even if those patients cannot pay for the care. *See, e.g.*, Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (requiring stabilization care); Pet. Br. (Minimum Coverage Provision) at 39-40 (citing EMTALA and other laws, including state laws).

Amici are not aware of data that specifically separate the costs of legally required stabilization care from the costs of all emergency care. Thus, it is difficult to quantify the precise increase in uncompensated care that would follow from the (entirely theoretical) decision of a State to end its existing Medicaid program. Research does show, however, that in 2007, Medicaid was the sole or partial payer in approximately 32.9 million emergency room visits. *See* Richard Niska et al., *National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary*, National Health Statistics Reports, No. 26, at 12 (Aug. 6, 2010), http://www.cdc.gov/nchs/data/nhsr/nhsr026.pdf.[5] This represents 28.2 percent of all emergency room visits in 2007, disproportionate to the percentage of the population that was covered by Medicaid in 2007 – 19.7 percent. *See* CMS, *Medicaid Enrollment by State*. Of those 32.9 million total Medicaid emergency room visits, approximately 18.1 million visits were triaged as being "urgent," or needing medical attention within 60 minutes or less of arrival.

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[5] This source combines Medicaid and Children's Health Insurance Program (CHIP). More than half of the States provide CHIP through Medicaid at least in part. *See* Centers for Medicare & Medicaid Servs., *Children's Health Insurance Program (CHIP)*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Childrens-Health-Insurance-Program-CHIP.html (last visited Jan. 17, 2012).

Thus, any State that did not provide Medicaid-like coverage would at least need to provide significant support to its hospitals and other providers that serve current Medicaid recipients; without such assistance, many such providers simply could not stay in business. The impact of such a collapse would be widespread, as "Medicaid members rely on the very same providers" as other patients. Decl. of Jerry L. Phillips (Undersecretary, La. Dep't of Health & Hospitals) at JA 135 ¶ 3; *see also, e.g.*, *id.* ("Eliminating Medicaid would mean that hospital uncompensated care would skyrocket, hospitals would have to close certain departments, stop expansion projects, and physicians would see a loss in revenue."); Decl. of Michael J. Willden, Dir., Dep't of Health & Human Servs., Nev., at JA 162 ¶ 5 ("Nursing facilities . . . would be at risk of closure," and "those with chronic medical conditions [would be] at serious risk.").

The ripple effect from such massive changes in the healthcare landscape would be simply huge. Putting States to the false fiscal "choice" imposed by the ACA's Medicaid expansion provisions – of either assuming such colossal federal funding cuts, requiring vast new state expenditures to maintain existing healthcare coverage levels for their neediest citizens, or else going along with Congress's policy preference by participating in a greatly enlarged Medicaid program – is plainly coercive and therefore unconstitutional.

CONCLUSION

For the foregoing reasons, this Court should reverse the decision of the Court of Appeals that the ACA's Medicaid expansion provisions do not unconstitutionally coerce States into adopting Congress's preferred policy program.

Respectfully submitted,

Steven G. Bradbury
Steven A. Engel
Counsel of Record
Michael H. Park
Elisa T. Wiygul
DECHERT LLP
1775 I Street, NW
Washington, DC 20006
(202) 261-3300
steven.engel@dechert.com

January 17, 2012

Counsel for Amici Curiae

APPENDIX

Appendix

LIST OF AMICI

Doug Holtz-Eakin
Former Director, Congressional Budget Office
American Action Forum

Edward C. Prescott
Nobel Prize Winner in Economics
Arizona State University

Vernon L. Smith
Nobel Prize Winner in Economics
Chapman University, George Mason University,
Mercatus Center

Lawrence Lindsey
Former Director, National Economic Council
The Lindsey Group

Arthur B. Laffer
First Chief Economist, Office of
Management and Budget
Laffer Associates

James C. Capretta
Former Associate Director, Office of
Management and Budget
Ethics and Public Policy Center

William Poole
Former President of the Federal Reserve Bank of
St. Louis
University of Delaware

Appendix

Douglas K. Adie
Ohio University

Scott W. Atlas
Stanford Medical School

Charles Baird
California State University, East Bay

Stacie E. Beck
University of Delaware

Sanjai Bhagat
University of Colorado

Michael Bond
University of Arizona

Carlos Bonilla
The Washington Group

Robert A. Book
HSI Network

Ike Brannon
American Action Forum

Edgar K. Browning
Texas A&M University

Lawrence Brunner
Central Michigan University

Richard V. Burkhauser
Cornell University

Charles W. Calomiris
Columbia University

Richard J. Cebula
Jacksonville Univesity

R. Morris Coats
Nicholls State University

John P. Cochran
Metropolitan State College of Denver

Robert Collinge
University of Texas at San Antonio

Peter F. Colwell
University of Illinois Urbana-Champaign

Michael Connolly
University of Miami

Kathleen B. Cooper
Southern Methodist University

Mike Cosgrove
University of Dallas

Eleanor D. Craig
University of Delaware

Nicole V. Crain
Lafayette College

Carl Dahlman
RAND Corporation

Appendix

Antony Davies
Duquesne University

Phoebus J. Dhrymes
Columbia University

Floyd H. Duncan
Virginia Military Institute

Francis J. Egan
Trinity College

Richard E. Ericson
East Carolina University

Dorla A. Evans
University of Alabama in Huntsville

Susan K. Feigenbaum
University of Missouri - St. Louis

Nicole Fisher
HSI Network

Fred Foldvary
Santa Clara University

Douglas C. Frechtling
The George Washington University

Diana Furchtgott-Roth
Manhattan Institute

Richard J. Grant
Lipscomb University

William R. Hart
Miami University (Ohio)

Kevin Hassett
American Enterprise Institute

David R. Henderson
Hoover Institution

Arlene Holen
Technology Policy Institute

Paul Howard
Manhattan Institute

James L. Huffman
Lewis & Clark Law School

Joseph M. Jadlow
Oklahoma State University

David L. Kendall
University of Virginia's College at Wise

Richard La Near
Missouri Southern State University

Norman B. Lefton
Southern Illinois University, Edwardsville

Thomas E. Lehman
Indiana Wesleyan University

Donald L. Luskin
Trend Macrolytics LLC

R. Ashley Lyman
University of Idaho

Henry G. Manne
George Mason University

Michael L. Marlow
California Polytechnic State University,
San Luis Obispo

Timothy Mathews
Kennesaw State University

John G. Matsusaka
University of Southern California

Merrill Matthews
Institute for Policy Innovation

W. Douglas McMillin
Louisiana State University

Roger Meiners
University of Texas - Arlington

Allan Meltzer
Carnegie Mellon University

James Moncur
University of Hawaii at Manoa

Michael R. Montgomery
University of Maine

Appendix

Michael Morrisey
University of Alabama at Birmingham

Robert D. Niehaus
Robert D. Niehaus, Inc.

James O'Neill
University of Delaware

Donald J. Oswald
California State University, Bakersfield

Stephen T. Parente
University of Minnesota

R. L. Promboin
University of Maryland University College

Michael J. Ramlet
American Action Forum

R. David Ranson
H. C. Wainwright & Co. Economics Inc.

Jon Reisman
University of Maine at Machias

Christine P. Ries
Georgia Institute of Technology

Nancy H. Roberts
Arizona State University

Larry L. Ross
University of Alaska, Anchorage

Timothy P. Roth
The University of Texas at El Paso

Paul H. Rubin
Emory University

Anthony B. Sanders
George Mason University

Tom Saving
Texas A&M University

Glen Schumock
University of Illinois - Chicago

Richard T. Selden
The University of Virginia

Alan C. Shapiro
University of Southern California

Mark H. Showalter
Brigham Young University

Cameron Smith
American Action Forum

James F. Smith
EconForecaster, LLC

Richard L. Smith
University of California, Riverside

Lawrence Southwick
University of Buffalo

Frank Spreng
McKendree University

Richard J. Sweeney
Georgetown University

Robert Tamura
Clemson University

John A. Tatom
Indiana State University

Stephen A. Tolbert, Jr.
Montgomery County Community College

William N. Trumbull
West Virginia University

Larry Van Horn
Vanderbilt University

Richard Vedder
Ohio University

Brian Wesbury
First Trust Advisors

Gary Wolfram
Hillsdale College

Joseph Zoric
Franciscan University of Steubenville

Appendix

FINDINGS AND METHODOLOGY

Economic Analysis of the Impact of Severability to Insurers Under the Patient Protection and Affordable Care Act

COSTS TO INSURERS ($ Billions):	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2012-2021**
Expanding Dependent Coverage to Age 26	$ (5.57)	$ (5.96)	$ (6.38)	$ (6.83)	$ (7.31)	$ (7.82)	$ (8.37)	$ (8.95)	$ (9.58)	$ (10.25)	$ (77.01)
Eliminating Annual/Lifetime Out-of-Pocket Limits	$ (4.10)	$ (4.39)	$ (4.16)	$ (4.45)	$ (4.76)	$ (5.10)	$ (5.45)	$ (5.83)	$ (6.24)	$ (6.68)	$ (51.16)
Excise Tax on Health Insurers	$ -	$ -	$ (6.10)	$ (9.30)	$ (9.50)	$ (11.40)	$ (11.70)	$ (12.10)	$ (13.92)	$ (16.00)	$ (90.02)
"Cadillac" Tax on High-Cost Health Plans	$ -	$ -	$ -	$ -	$ -	$ -	$ (24.40)	$ (39.04)	$ (60.51)	$ (93.79)	$ (217.75)
Expanded Essential Health Benefits Package	$ -	$ -	$ (27.25)	$ (29.15)	$ (31.20)	$ (33.38)	$ (35.72)	$ (38.22)	$ (40.89)	$ (43.75)	$ (279.55)
TOTAL	$ (9.67)	$ (10.35)	$ (43.89)	$ (49.73)	$ (52.76)	$ (57.69)	$ (85.63)	$ (104.14)	$ (131.14)	$ (170.46)	$ (715.49)

BENEFITS TO INSURERS ($ Billions):	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2012-2021**
Revenue from Expanded Private Coverage Under the Individual Mandate	$ -	$ -	$ 50.75	$ 49.23	$ 47.75	$ 46.32	$ 44.93	$ 43.58	$ 42.27	$ 41.01	$ 365.83
Revenue from Medicaid Expansion (Net of Crowd-Out of Other Insurance)			$ 34.65	$ 37.08	$ 39.67	$ 42.45	$ 45.42	$ 48.60	$ 52.00	$ 55.64	$ 355.50
TOTAL	$ -	$ -	$ 85.40	$ 86.30	$ 87.42	$ 88.77	$ 90.35	$ 92.18	$ 94.27	$ 96.65	$ 721.34
NET TO INSURERS	$ (9.67)	$ (10.35)	$ 41.51	$ 36.57	$ 34.66	$ 31.07	$ 4.71	$ (11.96)	$ (36.86)	$ (73.83)	$ 5.84
NET WITHOUT INDIVIDUAL MANDATE	$ (9.67)	$ (10.35)	$ (9.24)	$ (12.66)	$ (13.09)	$ (15.25)	$ (40.21)	$ (55.54)	$ (79.14)	$ (114.84)	$ (359.99)

This analysis was completed using the HEPSS-ARCOLA economic forecasting model, which is designed to estimate the impact of health policy proposals at federal and state levels. The model predicts individual adult responses to proposed policy changes and generalizes to the U.S. population with respect to health insurance coverage and the financial impact of the proposed changes.

The model is built on a foundation of data sources including claims data from several nationwide employers, the Medical Expenditure Panel Survey Household Component (MEPS-HC), and the Medical Expenditure Panel Survey Insurance Component (MEPS-IC).

This model was first used by the Office of the Assistant Secretary (OASPE) of the Department of Health and Human Services (DHHS) to simulate the effect of the Medicare Modernization Act of 2003 (MMA) on how quickly and how many consumers would adopt high-deductible health plans in the individual health insurance market. *See* Roger Feldman, Stephen T. Parente, Jean Abraham, et al., *Health Savings Accounts: Early Estimates Of National Take-Up*, 24 Health Affairs 1582 (Nov./Dec. 2005); Stephen T. Parente & Roger Feldman, *Continuation of Research on Consumer Directed Health Plans: HSA Simulation Model Refinement, Final Technical Report for DHHS Contract HHSP23320054301ER*, i (Jan. 21, 2007). The model was later refined to incorporate the effect of prior health status on health plan choice in order to predict enrollment more accurately. The current model uses insurance expenditures from actual health insurance claims data and Medicaid to estimate the state and federal impact of health policy changes.

The data used for this analysis are the Medical Expenditure Panel Survey (MEPS), ehealth.com, the 2011 Kaiser survey of health plans, and proprietary commercial insurance claims as well as benefit design information from several employers.

By inputting updated premium data into the model and then running the model through an iterative process, *amici* were able to estimate, for a ten-year projection period, the response of individuals to new health insurance choices, premium rates, plan participation, and other financial information in the presence of the ACA's various provisions. *See also* Douglas Holtz-Eakin, Stephen T. Parente & Michael J. Ramlet, *The Economic Implications of Severing the Individual Mandate*, American Action Forum, Jan. 5, 2012, http://bit.ly/EIoStIM.

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

IN THE

Supreme Court of the United States

NAT'L FEDERATION OF
INDEPENDENT BUSINESS, *ET AL.*,
Petitioners,
v.
KATHLEEN SEBELIUS, SECRETARY OF
HEALTH AND HUMAN SERVICES, *ET AL.*,
Respondents.

STATE OF FLORIDA, *ET AL.*,
Petitioners,
v.
DEPARTMENT OF HEALTH & HUMAN SERVICES, *ET AL.*,
Respondents.

**On Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit**

BRIEF FOR *AMICI CURIAE* ECONOMISTS IN SUPPORT OF PETITIONERS REGARDING SEVERABILITY

STEVEN G. BRADBURY
STEVEN A. ENGEL *
MICHAEL H. PARK
ELISA T. WIYGUL
DECHERT LLP
1775 I Street, NW
Washington, DC 20006
(202) 261-3300
steven.engel@dechert.com

* Counsel of Record

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

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INTEREST OF THE *AMICI CURIAE*[1]

Amici Curiae are 103 economists who have studied, researched, and participated in the national policy discussion relating to the healthcare markets. *Amici* include Nobel laureates, former senior government officials, and faculty from research universities around the country. *Amici* support the need for reform but believe that the Affordable Care Act ("ACA" or the "Act") will likely exacerbate, rather than constrain, the inflation in healthcare costs that poses a serious long-term challenge to the U.S. economy. A complete list of *amici* can be found in the Appendix, beginning on page 1a.

Amici previously filed a brief with the Court of Appeals for the Eleventh Circuit addressing the economic premises on which the Government relied in seeking to defend the ACA's individual mandate as a regulation of interstate commerce. The Eleventh Circuit expressly relied upon *amici*'s analysis in finding the mandate unconstitutional. *See Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1299 & nn.108-111, 113 (11th Cir. 2011). *Amici* intend to file similar briefs addressing the economic issues relating to the constitutionality of the individual mandate and the Act's Medicaid expansion according to the schedule this Court has ordered.

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[1] No counsel for any party has authored this brief in whole or in part, and no person other than *amici* or their counsel has made a monetary contribution to the preparation or submission of this brief. *See* Sup. Ct. R. 37.6. All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk of this Court.

Amici submit this brief in support of Petitioners' position that the Court of Appeals erred in holding that the individual mandate, which, along with related subsidies and the Act's Medicaid expansion, benefits private insurance companies, can be severed from the many other provisions of the Act that impose substantial costs on those private insurers. *Amici* seek to assist the Court in understanding the economic interconnectedness of the many complex provisions of the ACA. Those economics demonstrate the individual mandate's true centrality to the Act, as well as the shortcomings in the Eleventh Circuit's ruling that the individual mandate could be severed from the rest of the ACA.

SUMMARY OF ARGUMENT

The individual mandate cannot be severed from the rest of the Affordable Care Act because Congress would not have intended the economic effects of the Act without the mandate. Specifically, numerous provisions of the Act impose significant costs on healthcare market participants, primarily health insurance companies. Congress would not have imposed such costs without the countervailing benefits provided by the individual mandate, not just as a matter of politics, but because such an imposition would undermine the central goal of the Act to make health care more affordable. As a result, the ACA fails the severability test of whether the Act would function in a "*manner* consistent with the intent of Congress" absent the individual mandate. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (emphasis in original).

The economic analysis advanced by *amici* economists demonstrates that the ACA depends on the individual mandate to provide a significant portion of the benefit necessary to counterbalance the enormous costs the Act otherwise imposes on health insurance providers.

Using the best available economic data and the same projection methods employed by the Department of Health and Human Services, *amici* have estimated the impact of the most salient healthcare reforms, looking at both the costs and benefits to the health insurance industry. Without the individual mandate and related subsidies, the Act is projected to impose total net costs of $360 billion on health insurance companies from 2012 through 2021. With those provisions, however, the Act would provide a net $6 billion benefit over that same time period. In other words, from an economic perspective, the benefits of the individual mandate and subsidies to health insurance companies, along with benefits provided by the Act's Medicaid expansion, are projected to balance, nearly perfectly, the costs that the Act's various regulatory mandates impose on insurers.

The Government concedes that certain provisions of the Act, namely the community rating and guaranteed issue reforms, must stand or fall with the individual mandate. Yet this economic analysis demonstrates that the mandate is needed to counterbalance numerous provisions in the Act beyond those two reforms. The benefits to health insurance providers of expanded private coverage under the individual mandate and subsidies for insurance purchase far outweigh the costs imposed by the community rating and guaranteed issue reforms, taken alone. Congress understood the individual mandate to counterbalance a broader set of impositions on the insurance industry that include taxes such as the so-called "Cadillac" excise tax on high-cost health plans that appear elsewhere in the Act.

Insurance companies are not the only market actors that would bear the significant costs that the individual mandate is needed to counterbalance. First, and most obviously, a steep increase in insurers' costs would necessarily result in an increase in the premiums that those insurers charge consumers. Accordingly, to invalidate only the individual mandate, while maintaining the ACA's other, highly burdensome regulatory provisions, would strip away the provision of the Act that is essential to enable private insurers to provide consumers with anything close to affordable insurance. Indeed, Congress explicitly found that the purpose of the individual mandate was to reduce premiums. *See* ACA §§ 1501(a)(2)(F), (I), (J), 42 U.S.C. § 18091(a)(2)(F), (I), (J). Without the individual mandate, the ACA's reforms, including but not limited to guaranteed issue and community rating, would cause a steep *increase* in premiums – the opposite of Congress's express intent.

Second, the Act includes trade-offs for other actors in the healthcare system. For instance, hospitals and drug manufacturers face reduced reimbursement for certain Medicare expenditures, but those costs are offset in part by the increase in demand for health care manufactured by the individual mandate. As with health insurers, it is reasonable to expect that if these actors were required to bear significant new costs, they would seek to pass along those costs to healthcare consumers – a result diametrically opposed to Congress's intent, embodied in the very title of the Act, to make health care more affordable. Thus, Congress would not have intended to enact those provisions without providing the affected market participants with the countervailing benefit supplied by the individual mandate.

As a result, because the individual mandate is the key to the economic viability of so many provisions of the Act, this Court should not engage in a line-by-line analysis of whether particular individual provisions of the 2,700-page Act are or are not sufficiently independent from the individual mandate to be severed from it. As the District Court found under this Court's precedents, particularly *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320, 329-30 (2006), such an exercise would be a more intrusive incursion into legislative prerogative than simply striking down the entire Act and leaving it to Congress to rewrite the statute. *See Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1303-05 (N.D. Fla. 2011). In view of the interdependence among the various regulatory provisions under the Act, if this Court finds that the individual mandate is unconstitutional, then the Act's broader regulatory impositions, which depend in large part on the projected revenues generated by the individual mandate, must fall as well.

ARGUMENT

The individual mandate is the centerpiece of the Affordable Care Act. By compelling relatively healthy consumers to purchase health insurance at premiums exceeding the value of the health services they can expect to receive, the individual mandate directly subsidizes insurers. The purpose of that subsidy, both economically and politically, is to counterbalance the significant costs that many other provisions of the Act impose on insurers, and thus to enable insurers to offer health insurance at premiums that, while greater than they would be absent the Act, nonetheless remain affordable to consumers.

In ruling that the individual mandate could be severed from the rest of the Act, the Court of Appeals misread *Alaska Airlines*, 480 U.S. 678. In *Alaska Airlines*, this Court recognized that where, as here, the remaining provisions of a statute are literally *capable* of functioning independently from the constitutionally infirm provision, "[t]he more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress." *Id.* at 685 (emphasis in original).

In the ACA, Congress attempted to create a carefully calibrated scheme of interrelated costs and subsidies to expand access to health insurance while keeping costs affordable. *See Florida*, 780 F. Supp. 2d at 1299-1300. In order to understand the individual mandate's place in this scheme, it is necessary to see precisely how Congress struck the balance in the ACA. As an economic analysis of these provisions demonstrates, absent the individual mandate, the Act could not function in a "manner consistent with the intent of Congress," *Alaska Airlines*, 480 U.S. at 685 (emphasis omitted), and thus the mandate cannot be severed from the rest of the Act.

I. AS A MATTER OF BASIC ECONOMICS, THE ACA CANNOT FUNCTION "IN A MANNER CONSISTENT WITH THE INTENT OF CONGRESS" WITHOUT THE INDIVIDUAL MANDATE

A. Without The Economic Subsidy The Individual Mandate Would Provide, The Remainder Of The ACA Would Impose Huge Uncompensated Costs On Health Insurance Companies

Amici's economic analysis of the ACA, as detailed below and in the Appendix to this brief, demonstrates that the Act includes various provisions that impose significant costs on health insurance companies and that the individual mandate, related subsidies, and Medicaid expansion provide counterbalancing benefits to those companies, in effect providing insurers with a subsidy that allows them to lower costs to the consumers who voluntarily choose to purchase health insurance.[2]

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[2] The ACA's impact on the health insurance industry is described in greater detail in the industry's brief filed in support of certiorari. *See* Brief of America's Health Insurance Plans as *Amicus Curiae* in Partial Support of Certiorari Review at 3, *Nat'l Federation of Indep. Bus. v. Sebelius, U.S. Dep't of Health & Human Servs. v. Florida, Florida v. U.S. Dep't of Health & Human Servs.*, Nos. 11-393, 11-398, and 11-400 [hereinafter AHIP Certiorari Brief] ("At the root of this litigation are the individual mandate and its relationship to [the] ACA's remaining provisions. Taken together, those provisions will fundamentally shift the way that health insurance is configured, financed, marketed, and sold, eliminating many of the risk management measures upon which insurers have relied for decades."); *id.* at 7 (ACA will cause "seismic changes" for health

To determine the costs and benefits of the ACA to health insurers, *amici* employed the same projection model used by the Department of Health and Human Services based on data sources including claims data from several nationwide employers, as well as the Government's own authoritative Medical Expenditure Panel Survey (MEPS), specifically the Medical Expenditure Panel Survey Household Component (MEPS-HC) and the Medical Expenditure Panel Survey Insurance Component (MEPS-IC).[3] A complete chart of *amici*'s projections, along with a more detailed explanation of these sources and methodologies, is attached hereto in the Appendix, beginning at page 10a.

Based on this economic analysis, the centrality of the individual mandate, along with related subsidies, is clear: With it, insurance companies can be expected essentially to break even under the provisions of the Act over the course of the decade from 2012 through 2021. Without it, insurance companies would be subjected to estimated net costs of $360 billion over that same time period, which they would largely pass on to consumers in the form of higher premiums. In other words, without the individual mandate, the Act would result in dramatically in-

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insurers); *id.* at 8 (ACA's insurance reforms "requir[e] health plans to undertake a wholesale and fundamental overhaul of their methods for offering insurance").

[3] MEPS is collected and maintained under the auspices of the U.S. Department of Health and Human Services. *See* Medical Expenditure Panel Survey ("MEPS"), U.S. Dep't of Health & Human Servs., http://meps.ahrq.gov/mepsweb (last visited Jan. 4, 2012).

creased healthcare costs – the opposite of what Congress intended. Thus, the various regulatory burdens that the ACA imposes on insurers cannot be severed from the individual mandate because the mandate is the keystone that holds together the economic viability of the entire "carefully-balanced and clockwork-like statutory arrangement" that is the ACA. *Florida*, 780 F. Supp. 2d at 1299.

1. The ACA's insurance reforms and taxes will impose significant costs on health insurers

Absent the offsetting benefits from the individual mandate, related subsidies, and the Medicaid expansion, the costs the Act would impose on insurers are staggering. The Act's major insurance reforms and taxes would cost insurers an estimated total of more than $715 *billion* from 2012 through 2021. From a low of approximately $10 billion in 2012, before many of the major reforms such as guaranteed issue take effect, these costs are projected to rise every year, exceeding $100 billion per year in 2019 and $170 billion per year in 2021. *See* Appendix at 10a; *see also* Douglas Holtz-Eakin, Stephen T. Parente & Michael J. Ramlet, *The Economic Implications of Severing the Individual Mandate*, American Action Forum, Jan. 5, 2012, http://bit.ly/EIoStIM.

For comparison, IBISWorld estimates the health insurance industry's nationwide revenue at $677.3 billion in 2011 with a profit margin of 4.5%, or roughly $30.5 billion. *See* Sophia Snyder, *IBISWorld Industry Report 52411b: Health & Medical Insurance in the US* 7, 8, 45 (Dec. 2011). Even taking into account the annual inflation-adjusted revenue growth of 5.0% for health insurers projected from 2011 through 2016, *see id.* at 5, 11, the $71.5 billion in average annual costs that the ACA would impose on health insurers (if the benefits from the individual mandate and the Medicaid expansion were excluded, as described below) constitutes a very substantial percentage of their revenue and an amount that would dwarf their current profit margin.[4]

Based on *amici*'s analysis, the costs imposed by the Act include:

- expansion of dependent coverage to age 26 ($77 billion over ten years), ACA § 1001, 42 U.S.C. § 300gg-14(a);
- elimination of annual and lifetime out-of-pocket coverage limits ($51 billion), ACA §§ 1001, 10101(a), 42 U.S.C. § 300gg-11;
- an excise tax on health insurers ($90 billion), ACA §§ 9010, 10905, Health Care and Education Reconciliation Act of 2010 (HCERA) § 1406;
- the so-called "Cadillac" tax on high-cost health plans ($218 billion), ACA § 9001, 26 U.S.C. § 4980I; and
- the expanded essential health benefits package, which consists of the prohibition on consideration of pre-existing conditions, guaranteed issue, and community rating ($280 bil-

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[4] Indeed, as America's Health Insurance Plans has pointed out, the ACA, if left standing in whole or in part, will force health insurers to transform their business models fundamentally. *See* AHIP Certiorari Brief at 3, 7, 8.

> lion), ACA §§ 1201, 1255, 42 U.S.C. §§ 300gg (community rating), 300gg-1 (guaranteed issue), 300gg-3(a) (pre-existing conditions).

See Appendix at 10a.[5] *See also generally Florida*, 648 F.3d at 1365-71 (Appendix A to Eleventh Circuit Majority Opinion describing overall structure of the Act, by Title).

Accordingly, the expanded essential health benefits package – which consists of the core insurance reforms that even the Government concedes are not severable from the individual mandate – accounts for only about 39 percent ($280 billion of $715 billion) of the total costs to health insurers that *amici* predict. Other ACA provisions, such as the "Cadillac" tax, account for the rest of these costs. Thus, the Government's position that only the guaranteed issue and community rating provisions are not severable from the individual mandate is untenable in light of the economic realities that multiple other provisions of the Act will create for the health insurance industry.

2. The individual mandate will provide counterbalancing benefits to health insurers

On the other side of the ledger, expanded private coverage under the individual mandate and related subsidies would *benefit* insurers by approximately $366 billion during that same 2012 to 2021 time period.[6] Notably, this benefit of $366 billion far exceeds the cost of $280 billion from the expanded coverage reforms – once again belying the Government's position that only the core insurance reforms of guaranteed issue and community rating cannot be severed from the individual mandate.

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[5] In addition, other provisions of the Act, such as the requirements that plans cover certain preventive care for children, ACA § 1001, 42 U.S.C. §§ 300gg-13(a), are likely also to impose direct or indirect costs on insurers, but their effects are more difficult to quantify.

In particular, the individual mandate and related subsidies would provide annual benefits ranging from $51 billion in 2014, the first year of the mandate, to approximately $41 billion in 2021.[7] This benefit will occur because the mandate will push people who had previously made a rational economic decision not to purchase health insurance – that is, people who could expect the premiums they would pay to exceed the economic benefit they would receive from coverage – to enter the health insurance market.[8] Insurers, standing on the other side of that mandated transaction, would directly benefit from an exchange in which premiums they take in from newly mandated enrollees are likely to be greater than benefits they pay out. Thus, by compelling these consumers to purchase health insurance at disadvantageous prices, the individual mandate would subsidize the health insurance industry, which is necessary to counteract the costs otherwise imposed by the Act.

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[6] The benefits projected to accrue to health insurers under the individual mandate include the refundable and advanceable premium credits and cost-sharing subsidies that the Act provides to uninsured individuals and families with incomes from 133 percent to 400 percent of the Federal Poverty Level who purchase health insurance on the new exchanges the Act creates. *See* 26 U.S.C. § 36B; 42 U.S.C. § 18071. Because the total amount of these subsidies depends upon enrollment, including compulsory enrollment, it is not practicable to disaggregate the benefits associated with the individual mandate from those associated with these related subsidies. In addition, the mandate is designed to, and may be expected to, encourage consumers to purchase health insurance for reasons other than purely economic calculations, that is, because they wish to comply with the law.

[7] *Amici* project that the benefit to insurance companies as a result of the individual mandate and related subsidies will decrease over time because the rate of medical care cost growth, and therefore the rate of health insurance cost increases, is likely to outpace the penalties for non-compliance with the mandate and the subsidies the Act provides for those buying health insurance.

3. The Medicaid expansion also will provide a benefit to health insurers

In addition to the individual mandate, *amici* project that private insurers will receive a substantial benefit from the Act's expansion of Medicaid eligibility. To administer Medicaid, the States have increasingly turned to managed care, in which private insurance companies provide Medicaid benefits to individuals in return for fixed monthly payments from the States for each Medicaid patient. The Centers for Medicare and Medicaid Services (CMS) estimates that as of July 1, 2010, approximately 71 percent of Medicaid recipients were in managed care programs, up from 57 percent in 2001. *See* Centers for Medicare & Medicaid Services, *National Summary of Medicaid Managed Care Programs and Enrollment as of July 1, 2010*, https://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/2010Trends.pdf.

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[8] In particular, the individual mandate targets relatively young and healthy consumers, whose income exceeds the expanded class of those entitled to Medicaid and for whom the purchase of insurance at premiums set by community rating will in nearly all cases prove to be a bad economic bet.

The move to managed Medicaid has increased even during the past year. Seventeen States already require non-long-term care Medicaid enrollees to sign up for managed care; six require long-term care recipients to enroll in managed care plans; and at least 10 others, including Florida, Maryland, New Jersey, and Rhode Island, are considering introducing or expanding the use of managed care to long-term care. *See* Phil Galewitz, Kaiser Health News, *States Turn to Private Insurance Companies for Managed Care*, USA Today, Feb. 21, 2011.

The ACA provides that Medicaid coverage will be expanded to cover those with incomes of up to 133 to 138 percent of the Federal Poverty Level beginning in 2014. *See* ACA §§ 2001, 2002, 42 U.S.C. § 1396a. This expanded coverage is projected to increase enrollment by as many as 16 to 20 million individuals and to increase costs by $428 billion between 2014 and 2019. *See* Centers for Medicare & Medicaid Services, *2010 Actuarial Report on the Financial Outlook for Medicaid*, i, iv, 27-28 (Dec. 21, 2010) [hereinafter CMS 2010 Report], https://www.cms.gov/ActuarialStudies/downloads/MedicaidReport2010.pdf; Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, House of Reps. 9 (Mar. 20, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf (16 million additional enrollees in Medicaid and Children's Health Insurance Program (CHIPS)). In its projections of Medicaid costs, the CMS "assum[es] that many of the newly eligible Medicaid enrollees in 2014 will be enrolled in Medicaid managed care plans, as has been true of currently enrolled children and adults." CMS 2010 Report at 20; *see also id.* at 24 (referring to "the increasing proportion of the adult Medicaid population enrolled in managed care plans").

As a result of the ACA's Medicaid expansion, private insurance companies are projected to benefit from $35 billion in 2014 up to nearly $56 billion in 2021, net of the industry's expected loss of some customers that previously had private insurance but will switch to non-managed care Medicaid, for a total benefit of $356 billion.[9]

4. The individual mandate and Medicaid expansion will provide benefits proportionate to the increased regulatory costs under the ACA

Taken together, the Act's Medicaid expansion and the individual mandate and related subsidies will provide a total benefit to health insurers of approximately $721 billion from 2012 to 2021. These benefits will effectively neutralize the increased costs the Act imposes on health insurers. Before the individual mandate and Medicaid expansion go into effect in 2014, and also before most of the corresponding cost-imposing provisions go into effect, the Act is estimated to cost insurers about $10 billion per year. (The fact that both the benefit and the cost provisions phase in over time provides further evidence that these provisions were intended to work hand in hand.) Then, from approximately 2014 to 2017, the Act will provide a net benefit to insurers of $31 to $42 billion per year. In 2018, insurers can be expected to break even, relatively speaking, and then starting in 2019, the Act's costs will again increasingly exceed its benefits.[10] *See* Appendix at 10a.

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[9] As a result of this significant benefit supplied by the Medicaid expansion, this economic analysis also supports the conclusion that those provisions, like the individual mandate, is non-severable from the rest of the Act.

Consistent with Congress's intent to expand health insurance coverage while minimizing the increase in premiums, the total costs and benefits from this snapshot of the Act's complex economic effects nearly balance each other out, leaving just a $5.8 billion total net benefit to insurers during the decade from 2012 through 2021. *See* Appendix at 10a. This is not a coincidence. Removing the individual mandate from this carefully balanced accounting would thus fundamentally upset the legislative design of the Act.

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[10] This cost/benefit imbalance will result largely because, with rising healthcare costs, more and more healthcare plans will fall within the range that is subject to the "Cadillac" tax. *See* Appendix at 10a.

B. The Individual Mandate Also Mitigates The Costs That The ACA Would Impose On Other Market Participants

1. The benefit to insurers from the individual mandate would translate into decreased premiums for consumers

Amici's economic analysis as presented in the Appendix has focused upon the direct impact that, *ceteris paribus*, the ACA can be projected to have on insurance companies. Yet the individual mandate's subsidy to insurers is not an end in itself. As Congress was well aware, the individual mandate was necessary to ensure that the costs of the Act's regulatory mandates are not passed on to consumers.

As the Congressional Budget Office (CBO) reported in late 2009, without the individual mandate, the ACA's reforms, including but not limited to the guaranteed issue and community rating reforms, would cause a substantial increase in the premiums consumers could expect to pay. *See* Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 5, 6 (Nov. 30, 2009), http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf (analyzing a Senate proposal very similar to the ACA as enacted and estimating that average premiums in nongroup market would be 27 to 30 percent higher because of expanded coverage but 7 to 10 percent lower because of additional enrollees and an additional 7 to 10 percent lower because of other rule changes affecting insurance companies). In fact,

seven months after providing this analysis, the CBO, along with Congress's Joint Committee on Taxation (JCT), estimated that eliminating the individual mandate would result in "adverse selection," which "would increase premiums for new non-group policies . . . by an estimated 15 to 20 percent relative to current law [with the ACA fully intact]." Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010),
http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf.

Eliminating the individual mandate would increase premiums because insurers can be expected to attempt to pass along new costs to consumers who purchase health insurance. The size of the premium rate increases that insurance providers will actually be able to charge, however, will likely be limited by several factors, including competition from the exchanges the ACA sets up, 42 U.S.C. § 18031, new and more stringent medical loss ratio requirements under the ACA, *id.* § 300gg-18, and State and federal monitoring of premium increases, *id.* § 300gg-94.

To the extent that increased costs for insurers are ultimately borne by consumers of health insurance in the form of elevated premiums, Congress would not have intended to pass a law that would cause such premium increases without the countervailing force of the individual mandate and related subsidies exerting downward pressure on premiums. The individual mandate is widely projected to mitigate that increase in premiums for precisely the reason that Congress intended: The individual mandate forces healthy people who are not participants in the health insurance market to join that market.

The intent of Congress to take advantage of this link between the individual mandate and lower health insurance premiums is beyond dispute, as Congress explicitly found that

> [b]y significantly increasing health insurance coverage, the [individual mandate] requirement, together with the other provisions of this Act, will minimize . . . adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

ACA § 1501(a)(2)(I), 42 U.S.C. § 18091(a)(2)(I); *see also* ACA § 1501(a)(2)(F), 42 U.S.C. § 18091(a)(2)(F) ("By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums."); ACA § 1501(a)(2)(J), 42 U.S.C. § 18091(a)(2)(J) (the individual mandate will increase economies of scale, thereby lowering premiums); Petition for Writ of Certiorari of U.S. Department of Health and Human Services at 7, 24, *U.S. Department of Health & Human Servs. v. Florida*, No. 11-400 (quoting ACA § 1501(a)(2)(I), 42

U.S.C. § 18091(a)(2)(I)).[11] If the individual mandate is invalidated as unconstitutional, then the link between the mandate and these premium reductions would be broken and Congress's objective of lowering premiums would be thwarted.

2. The individual mandate would also offset costs the ACA imposes on other market participants

The individual mandate can also be expected to subsidize other market participants that are subject to costs as a result of other provisions of the Act. For instance, hospitals and drug manufacturers face several provisions that will reduce their revenue, including lower Medicare payments for hospitals "because of productivity adjustments to the annual 'market-basket' updates" and lower Medicare payments for drug manufacturers in Medicare Part D's so-called donut hole. Bradley Herring, *An Economic Perspective on the Individual Mandate's Severability from the ACA*, 364 New England Journal of Medicine e16 (Mar. 10, 2011), http://www.nejm.org/doi/full/10.1056/NEJMpv1101519. As Herring points out, drug manufacturers, medical device manufacturers, and health insurers will each also be subject to a new flat fee or tax under the ACA. *See id.*

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[11] In addition, as America's Health Insurance Plans has pointed out, Congress legislated in the shadow of the adverse experiences of numerous States that have enacted community rating and guaranteed issue reforms but not individual mandates. *See* AHIP Certiorari Brief at 19-22.

The individual mandate provides a subsidy to these market actors that mitigates the effects of these provisions: "These [cost-imposing] provisions seemed politically possible because the healthcare industry was willing to make concessions on prices and fees in return for the large increase in the number of people with insurance that was expected to occur under the ACA," *id.*, because of the individual mandate, related subsidies, and Medicaid expansion. "A large body of research suggests" that an increase in the ranks of America's insured would likely lead to greater healthcare consumption. *Id.* This would provide a boon to hospitals and drug manufacturers.

Indicative of the Act's sprawling and interconnected structure, the cost-imposing provisions Herring highlights are *not* located within Title I of the Act, the title dealing explicitly with insurance regulation. *See, e.g.*, ACA § 3301, codified at, *e.g.*, 42 U.S.C. §§ 1395w-102(b), 1395w-114a, 1395w-153 (Title III of the Act, which, among other changes to Medicare, "revises the Medicare Part D prescription drug program and reduc[ing] the so-called 'donut hole' coverage gap in that program," *Florida*, 648 F.3d at 1368). *See generally Florida*, 648 F.3d at 1365-71 (Appendix A to Eleventh Circuit Majority Opinion describing overall structure of the Act, by Title).

II. GIVEN THAT THE INDIVIDUAL MANDATE IS TIED TO SO MANY SECTIONS OF THE ACT, THERE IS NO PRACTICAL WAY FOR THE COURT TO SEVER THE MANDATE AND PRESERVE THE ACT

The preceding discussion demonstrates that the individual mandate provides an essential counterbalance to what would otherwise be substantial costs to market participants including health insurance companies, consumers of insurance, hospitals, and drug manufacturers. As this Court has noted, when courts evaluate remedies, including severability, when part of a statute is unconstitutional, they must, among other considerations, "restrain [themselves] from 'rewrit[ing] [a] law to conform it to constitutional requirements' even as we strive to salvage it." *Ayotte*, 546 U.S. at 329 (quoting *Virginia v. Am. Booksellers Ass'n*, 484 U.S. 383, 397 (1988)) (second alteration in original); *see also Florida*, 780 F. Supp. 2d at 1303 (quoting *Ayotte*).

Thus, "where" – as here – "line-drawing is inherently complex," engaging in a provision-by-provision analysis to invalidate many of the Act's provisions but perhaps not others "may call for a 'far more serious invasion of the legislative domain' than we ought to undertake." *Ayotte*, 546 U.S. at 330 (quoting *United States v. Nat'l Treasury Employees Union*, 513 U.S. 454, 479 n.26 (1995)). The District Court understood that this principle requires the ACA to be invalidated in its entirety once the individual mandate has been adjudged unconstitutional. *Florida*, 780 F. Supp. 2d at 1303-05. As that court correctly observed, without the individual mandate, the Act

> cannot function as originally designed. There are simply too many moving parts in the Act and too many provisions dependent (directly and indirectly) on the individual mandate and other health insurance provisions – which, as noted, were the chief engines that drove

> the entire legislative effort – for me to try and dissect out the proper from the improper, and the able-to-stand-alone from the unable-to-stand-alone. Such a quasi-legislative undertaking would be particularly inappropriate in light of the fact that any statute that might conceivably be left over after this analysis is complete would plainly not serve Congress' main purpose and primary objective in passing the Act.

Id. at 1304-05.

Amici's economic analysis reinforces this conclusion by demonstrating the economic reality that the individual mandate is intertwined with a host of ACA provisions, not simply the core insurance reforms. As a result, the mandate cannot be severed from the remainder of the ACA.

CONCLUSION

For the foregoing reasons, if the Court upholds the Eleventh Circuit's judgment that the individual mandate is unconstitutional, then the decision as to severability should be reversed.

Respectfully submitted,

Steven G. Bradbury
Steven A. Engel
Counsel of Record
Michael H. Park
Elisa T. Wiygul
DECHERT LLP
1775 I Street, NW
Washington, DC 20006
(202) 261-3300
steven.engel@dechert.com

January 6, 2012

Counsel for Amici Curiae

APPENDIX

LIST OF AMICI

Douglas Holtz-Eakin
American Action Forum
Former Director, Congressional Budget Office

Edward C. Prescott
Arizona State University
Nobel Prize Winner in Economics

Vernon L. Smith
Chapman University, George Mason University,
Mercatus Center
Nobel Prize Winner in Economics

June O'Neill
Baruch College, CUNY
Former Director, Congressional Budget Office

Arthur B. Laffer
Laffer Associates
Former Chief Economist, Office of
Management and Budget

Larry Lindsey
The Lindsey Group
Former Director, National Economic Council

Douglas K. Adie
Ohio University

William Albrecht
University of Iowa

Scott W. Altas
Stanford Medical School

Charles Baird
California State University, East Bay

Lawrence J. Belcher
Taylor University

Sanjai Bhagat
University of Colorado

Michael Bond
University of Arizona

Carlos Bonilla
The Washington Group

Robert A. Book
American Action Forum

Ike Brannon
American Action Forum

Edgar K. Browning
Texas A&M University

Lawrence Brunner
Central Michigan University

Richard V. Burkhauser
Cornell University

Charles W. Calomiris
Columbia University

Cameron Smith
American Action Forum

Richard J. Cebula
Jacksonville Univesity

R. Morris Coats
Nicholls State University

John P. Cochran
Metropolitan State College of Denver

John H. Cochrane
University of Chicago

Robert Collinge
University of Texas at San Antonio

Peter F. Colwell
University of Illinois Urbana-Champaign

Michael Connolly
University of Miami

Kathleen B. Cooper
Southern Methodist University

Mike Cosgrove
University of Dallas

Eleanor D. Craig
University of Delaware

Nicole V. Crain
Lafayette College

Carl Dahlman
RAND Corp.

Coldwell Daniel III
University of Memphis

Antony Davies
Duquesne University

Phoebus J. Dhrymes
Columbia University

Floyd H. Duncan
Virginia Military Institute

Francis J. Egan
Trinity College

Stephen J. Entin
Institute for Research on the Economics of Taxation

Richard E. Ericson
East Carolina University

Dorla A. Evans
University of Alabama in Huntsville

Fred Foldvary
Santa Clara University

Douglas C. Frechtling
The George Washington University

Luke Froeb
Vanderbilt University

Diana Furchtgott-Roth
Manhattan Institute

Richard J. Grant
Lipscomb University

William R. Hart
Miami University (Ohio)

Joseph H. Haslag
University of Missouri

Kevin Hassett
Economic Policy Studies,
American Enterprise Institute

David R. Henderson
Hoover Institution

Arlene Holen
Technology Policy Institute

C. Thomas Howard
University of Denver

Paul Howard
Manhattan Institute

James L. Huffman
Lewis & Clark Law School

Joseph M. Jadlow
Oklahoma State University

David L. Kendall
The University of Virginia's College at Wise

Norman B. Lefton
Southern Illinois University Edwardsville

Thomas E. Lehman
Indiana Wesleyan University

Phil I. Levy
American Enterprise Institute

Donald L. Luskin
Trend Macrolytics LLC

R. Ashley Lyman
University of Idaho

Glenn MacDonald
Washington University in St. Louis

Henry G. Manne
George Mason University

Michael L. Marlow
Cal PolySan Luis Obispo

Timothy Mathews
Kennesaw State University

Merrill Matthews
Institute for Policy Innovation

Roger Meiners
University of Texas - Arlington

Allan Meltzer
Carnegie Mellon University

Eugenio J. Miravete
University of Texas at Austin

James Moncur
Hawaii at Manoa

Nicole Fisher
Health Systems Innovation Network

Robert D. Niehaus
Robert D. NiehausInc.

James O'Neill
University of Delaware

Donald J. Oswald
California State University Bakersfield

Stephen T. Parente
University of Minnesota

R. L. Promboin
University of Maryland University College

Richard W. Rahn
Institute for Global Economic Growth

Michael J. Ramlet
American Action Forum

R. David Ranson
H. C. Wainwright & Co. Economics Inc.

Jon Reisman
University of Maine at Machias

Christine P. Ries
Georgia Institute of Technology

Nancy H. Roberts
Arizona State University

Larry L. Ross
University of Alaska, Anchorage

Timothy P. Roth
The University of Texas at El Paso

Paul H. Rubin
Emory University

Anthony B. Sanders
George Mason University

Thomas Saving
Texas A&M University

Richard T. Selden
The University of Virginia

Alan C. Shapiro
University of Southern California

Mark H. Showalter
Brigham Young University

James F. Smith
EconForecaster, LLC

Richard L. Smith
University of California, Riverside

Lawrence Southwick
University of Buffalo

Robert Tamura
Clemson University

John A. Tatom
Indiana State University

Stephen A. Tolbert, Jr.
Montgomery County Community College

William N. Trumbull
West Virginia University

Larry Van Horn
Vanderbilt University

Richard Vedder
Ohio University, American Enterprise Institute

Brian S. Wesbury
First Trust Portfolios, LP

Gary Wolfram
Hillsdale College

Joseph Zoric
Franciscan University of Steubenville

Benjamin Zycher
American Enterprise Institute, Pacific Research Institute

Appendix

FINDINGS AND METHODOLOGY

Economic Analysis of the Impact of Severability to Insurers Under the Patient Protection and Affordable Care Act

COSTS TO INSURERS ($ Billions):	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012-2021
Expanding Dependent Coverage to Age 26	$ (5.57)	$ (5.96)	$ (6.38)	$ (6.83)	$ (7.31)	$ (7.82)	$ (8.37)	$ (8.95)	$ (9.58)	$ (10.25)	$ (77.01)
Eliminating Annual/Lifetime Out-of-Pocket Limits	$ (4.10)	$ (4.39)	$ (4.16)	$ (4.45)	$ (4.76)	$ (5.10)	$ (5.45)	$ (5.83)	$ (6.24)	$ (6.68)	$ (51.16)
Excise Tax on Health Insurers	$ -	$ -	$ (6.10)	$ (9.30)	$ (9.50)	$ (11.40)	$ (11.70)	$ (12.10)	$ (13.92)	$ (16.00)	$ (90.02)
"Cadillac" Tax on High-Cost Health Plans	$ -	$ -	$ -	$ -	$ -	$ -	$ (24.40)	$ (39.04)	$ (60.51)	$ (93.79)	$ (217.75)
Expanded Essential Health Benefits Package	$ -	$ -	$ (27.25)	$ (29.15)	$ (31.20)	$ (33.38)	$ (35.72)	$ (38.22)	$ (40.89)	$ (43.75)	$ (279.55)
TOTAL	$ (9.67)	$ (10.35)	$ (43.89)	$ (49.73)	$ (52.76)	$ (57.69)	$ (85.63)	$ (104.14)	$ (131.14)	$ (170.46)	$ (715.49)
BENEFITS TO INSURERS ($ Billions):	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2012-2021**
Revenue from Expanded Private Coverage Under the Individual Mandate	$ -	$ -	$ 50.75	$ 49.23	$ 47.75	$ 46.32	$ 44.93	$ 43.58	$ 42.27	$ 41.01	$ 365.83
Revenue from Medicaid Expansion (Net of Crowd-Out of Other Insurance)			$ 34.65	$ 37.08	$ 39.67	$ 42.45	$ 45.42	$ 48.60	$ 52.00	$ 55.64	$ 355.50
TOTAL	$ -	$ -	$ 85.40	$ 86.30	$ 87.42	$ 88.77	$ 90.35	$ 92.18	$ 94.27	$ 96.65	$ 721.34
NET TO INSURERS	$ (9.67)	$ (10.35)	$ 41.51	$ 36.57	$ 34.66	$ 31.07	$ 4.71	$ (11.96)	$ (36.86)	$ (73.83)	$ 5.84
NET WITHOUT INDIVIDUAL MANDATE	$ (9.67)	$ (10.35)	$ (9.24)	$ (12.66)	$ (13.09)	$ (15.25)	$ (40.21)	$ (55.54)	$ (79.14)	$ (114.84)	$ (359.99)

Appendix

This analysis was completed using the HEPSS-ARCOLA economic forecasting model, which is designed to estimate the impact of health policy proposals at federal and state levels. The model predicts individual adult responses to proposed policy changes and generalizes to the U.S. population with respect to health insurance coverage and the financial impact of the proposed changes.

The model is built on a foundation of data sources including claims data from several nationwide employers, the Medical Expenditure Panel Survey Household Component (MEPS-HC), and the Medical Expenditure Panel Survey Insurance Component (MEPS-IC).

This model was first used by the Office of the Assistant Secretary (OASPE) of the Department of Health and Human Services (DHHS) to simulate the effect of the Medicare Modernization Act of 2003 (MMA) on how quickly and how many consumers would adopt high-deductible health plans in the individual health insurance market. *See* Roger Feldman, Stephen T. Parente, Jean Abraham, et al., *Health Savings Accounts: Early Estimates Of National Take-Up*, 24 Health Affairs 1582 (Nov./Dec. 2005); Stephen T. Parente & Roger Feldman, *Continuation of Research on Consumer Directed Health Plans: HSA Simulation Model Refinement, Final Technical Report for DHHS Contract HHSP23320054301ER*, i (Jan. 21, 2007). The model was later refined to incorporate the effect of prior health status on health plan choice in order to predict enrollment more accurately. The current model uses insurance expenditures from actual health insurance claims data and Medicaid to estimate the state and federal impact of health policy changes.

The data used for this analysis are the Medical Expenditure Panel Survey (MEPS), ehealth.com, the 2011 Kaiser survey of health plans, and proprietary commercial insurance claims as well as benefit design information from several employers.

By inputting updated premium data into the model and then running the model through an iterative process, *amici* were able to estimate, for a ten-year projection period, the response of individuals to new health insurance choices, premium rates, plan participation, and other financial information in the presence of the ACA's various provisions. *See also* Douglas Holtz-Eakin, Stephen T. Parente & Michael J. Ramlet, *The Economic Implications of Severing the Individual Mandate*, American Action Forum, Jan. 5, 2012, http://bit.ly/EIoStIM.

AMICUS CURIAE BRIEF

No. 11-400

IN THE

Supreme Court of the United States

STATE OF FLORIDA, *et al.*
Petitioners,

v.

U.S. DEPT. OF HEALTH & HUMAN SERVICES, *et al.*,
Respondent.

On Writ of Certiorari to the
U.S. Court of Appeals
for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* SUBMITTED ON BEHALF OF FAITHFUL REFORM IN HEALTH CARE AND THE WISC HEALTH CARE WORKING GROUP IN SUPPORT OF RESPONDENT'S POSITION ON MEDICAID

THOMAS W. COONS
Counsel of Record
CHARLES M. ENGLISH
WENDY M. YOVIENE
OBER, KALER,
GRIMES & SHRIVER
A Professional Corporation
1401 H Street, N.W.
Fifth Floor
Washington, D.C. 20005
(202) 408 8400
twcoons@ober.com

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

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STATEMENTS OF INTEREST OF *AMICI CURIAE*[1]

This brief is submitted on behalf of diverse religious organizations[2] to inform the Court about the moral imperatives that impel the faith communities to support the Medicaid expansions and improvements in the Affordable Care Act ("ACA"). The over 60 *amici* organizations noted in footnote two work together as coalition partners through Faithful Reform in Health Care and/or the Washington Interreligious Staff Community (WISC) Health Care Working Group.

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[1] Counsel for the parties filed blanket consents to *amicus* briefs in this case. Counsel for *amici* timely notified counsel of record of its intent to file this brief. No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money to fund preparation or submission of this brief. No person, other than *amici*'s counsel, contributed money intended to fund preparation or submission of this brief.

[2] *Amici* are: American Baptist Home Mission Society; American Muslim Health Professionals; Association of Professional Chaplains; Buddhist Peace Fellowship; Central Conference of American Rabbis; Disciples Home Missions, Christian Church (Disciples of Christ) in the United States and Canada; Disciples Justice Action Network; Church of the Brethren; Everence Financial (formerly Mennonite Mutual Aid); Face to Face International Outreach Ministries; Faithful Reform in Health Care; Global Justice Institute; Interfaith Center on Corporate Responsibility; Islamic Medical Association of North America; Jewish Reconstructionist Federation; Mennonite Central Committee U.S. Washington Office; Mennonite Healthcare Fellowship; Metropolitan Community Churches; The Fellowship of Affirming Churches; The General Synod of the United Church of Christ; Union for Reform Judaism; Unitarian Universalist Association; United Methodist Church – General Board of Church and Society; Washington Interreligious Staff Community Health Care Working Group; Reverend Gradye Parsons, Stated Clerk of the General Assembly, Presbyterian Church (U.S.A), on behalf of the Social Policy of the General Assembly; Arkansas Interfaith Alliance; California Council of Churches; Catholic Health East, Pennsylvania; Detroit Interfaith Outreach Network; Faith Action Network of Washington; Holy Family Institute, Pennsylvania; Interfaith Health and Hope Coalition, Michigan; Ohio Council of Churches; Progressive Action for the Common Good, Iowa, Illinois; Michigan Unitarian Universalist Social Justice Network; Missouri Health Care for All; Missouri Interfaith IMPACT; North Carolina Council of Churches; Social Justice

Faithful Reform in Health Care, founded in 2007, is the largest interfaith coalition of national, state, and local organizations, congregations, and individuals working together around a shared moral vision for the kind of health system that would include everyone. Comprising Protestants, Catholics,

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Mission Area Team, Detroit Metropolitan Association, United Church of Christ; Texas Impact; Wisconsin Council of Churches; Benedictine Sisters, Boerne, Texas; Congregation of the Sisters of Charity of the Incarnate Word, Texas; Dominican Congregation of Our Lady of the Rosary, New York; Dominican Sisters of Hope; Justice and Peace Committee of the Sisters of St. Joseph of Springfield, Massachusetts; Marianist Province of the United States; Sisters of Charity of St. Elizabeth Leadership Team, New Jersey; Sisters of Charity of St. Vincent De Paul of New York; Sisters of the Holy Cross Congregation Justice Committee; Sisters of the Incarnate Word and Blessed Sacrament, Corpus Christi, Texas; Sisters of Mercy West Midwest Justice Team, Nebraska; Sisters of the Most Precious Blood, Missouri; Sisters of the Presentation of the Blessed Virgin Mary, New York; Sisters of St. Dominic Congregation of the Most Holy Name; Society of the Holy Child Jesus, American Province Leadership Team; Ursuline Sisters of Tildonk, US Province; JOLT, Catholic Coalition for Responsible Investing; Region VI Coalition for Responsible Investment, Ohio, Kentucky, Tennessee; School Sisters of Notre Dame Cooperative Investment Fund; Tri-State Coalition for Responsible Investment; Cote Brilliante Presbyterian Church, Missouri; Parkside Community Church, United Church of Christ, California; and United Methodist Women, Biltmore United Methodist Church.

Evangelical Christians, Jews, Muslims, Unitarians, Buddhists, and others, the coalition has focused on educating its members about the challenges in U.S. health care, as well as the needed changes in public policy that could lead to the creation of a health care system that better meets the needs of all. In addition to advocating system reform generally, when necessary, the coalition has engaged in educational and advocacy efforts specifically focused on protecting, strengthening, and expanding programs such as Medicaid, the Children's Health Insurance Program ("CHIP"), and Medicare. Supporting the Medicaid improvements and expansions in the ACA is consistent with the Coalition's history and mission.

The WISC Health Care Working Group provides a forum through which leaders in the Washington, D.C. offices of national faith groups connect to one another around numerous health care issues. The missional activities of the group include maintaining relationships with the legislative and executive branches of the federal government; communicating legislative activities to their constituencies; communicating moral priorities to the President and Congress; and engaging in education and advocacy around health care issues that are addressed by the social justice policies of the member organizations. This group has consistently served as the link between federal policy and outreach and the work of the Faithful Reform coalition, including efforts that focus on Medicaid, CHIP, and Medicare.

Amici believe that passage of the ACA, which included important Medicaid improvements and expansions, marked a significant step toward the faith community's long-held vision of a system of health care that includes, and works well for, all.

Amici celebrate the ACA as the first time our country successfully made a national legislative commitment to develop a health care system that will give almost everyone in the United States access to our nation's abundant health care resources.

For decades, faith communities have worked both individually and collectively to move our nation toward a more inclusive and just system of health care—with particular focus on the poor and vulnerable. Since 2008 *amici* have been guided in their work by "A Faith-Inspired Vision of Health Care," an interfaith statement of the shared value of health care for all. (*Available at* http://www.faithfulreform.org and printed for the Court's convenience in Appendix A). Hundreds of organizations and thousands of individuals representing every state signed on to this vision statement, and Faithful Reform in Health Care delivered it to President Obama and Members of Congress on several occasions to help identify the faith community's perspective on how a present day government might respond to the moral imperative of health care for all.

This vision states, "As people of faith, we envision a society where each person is afforded health, wholeness, and human dignity." That vision embraces a system of health care that is: inclusive, affirming that health care is a shared responsibility grounded in our common humanity; affordable, confirming that health care must contribute to the common good by being affordable for individuals, families and society as a whole; accessible, ensuring that all persons have the health services that provide necessary care and contribute to wellness; and accountable, offering a quality, equitable and sustainable means of keeping us healthy as individuals and as a community. Id.

Amici have been among those at the heart of support for meaningful health care reform in the United States. Grounded in values that inspire them to work on behalf of the common good, *amici* have promoted a moral vision for the nation's health care future and raised voices in support of affordable quality health care for all. Such commitment is a logical extension of *amici's* calling to bring comfort and healing to those who suffer, with particular concern for the poor and vulnerable who are served by Medicaid and for whom the ACA's Medicaid provisions are particularly significant.

SUMMARY OF ARGUMENT

Amici represent those faith communities that characterize our country's religious diversity. While these groups have different perspectives on many issues, they all agree that it is the calling of government to bring justice and protection to the poor and the sick, a goal that is consistent with the U.S. Constitution. For this reason, *amici* have long supported Medicaid, our nation's program for health care for the poor.

The Medicaid program was created as an amendment (Title XIX) to the Social Security Act ("SSA"). Congress passed the original SSA in the depths of the Great Depression because the states, which had traditionally provided for the welfare of the poor, were overwhelmed by the extent of the need. The SSA created the cooperative federal and state assistance programs upon which Medicaid was ultimately based. Although the original SSA did not include health insurance, the statute was amended in the 1950s and 1960s to provide the states with some health care funding. Later, the Medicaid program, created by 1965 amendments to the SSA, firmly established a federal role in funding health care and provided a legal framework for state Medicaid programs.

State Medicaid programs vary considerably. To ensure a level of minimum coverage from state to state, however, the federal government requires that the states furnish certain levels of services and cover certain populations. Since 1965, Congress has regularly expanded that coverage under the Medicaid program. The ACA's Medicaid expansions are only the latest in this series and complete a long-term trend of expanding Medicaid to cover all poor Americans.

Congress expanded Medicaid through the ACA in response to another historical crisis—the needs of fifty million uninsured Americans, many of whom are too poor to afford health insurance. Although pre-ACA Medicaid expansions and the creation of CHIP decreased dramatically the percentage of uninsured American children, the number of uninsured American adults has continued to grow. The ACA's Medicaid expansions respond to this crisis, expanding health care coverage to all adults with incomes below 133 percent of the federal poverty level.

This expansion is morally proper and legally permissible. Neither the facts nor the case law support any conclusion that states are or will be improperly coerced into participating in Medicaid. Congress has never required the states to participate in Medicaid. Rather, the ACA offers the states generous support for Medicaid expansion, 100 percent of which will be paid for by the federal government in the near term. Because states can opt out of Medicaid, the only compulsion they face is the knowledge that the

Medicaid expansion is the right and moral thing to do. This Court, therefore, should reject the states' claim and affirm the constitutionality of the ACA's Medicaid expansions.

ARGUMENT

I. THE OBLIGATION TO CARE FOR THE HEALTH OF THE POOR, UNIVERSALLY RECOGNIZED BY RELIGIOUS ORGANIZATIONS, IS AMONG THIS COUNTRY'S FUNDAMENTAL VALUES AND IS FURTHERED BY THE ACA'S EXPANSION OF MEDICAID.

When the people of the United States established a Constitution for its government, they identified a significant purpose of government as promoting the general welfare. In so doing, they identified a moral imperative of government: to seek the common good of the American people. The faith community understands and endorses the government's legitimate and necessary role in promoting the common good.[3] The scriptures of the Abrahamic traditions of Christians, Jews, and Muslims, in addition to the sacred teachings of other faiths, understand that addressing the general welfare of the nation includes giving particular attention to the poor and the sick.

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[3] For instance, the Presbyterian Church (U.S.A.) summarized what many faith groups affirm – that ". . . civil government is ordained by God to order and serve the human community and therefore is to be held in high respect and honor . . . The civil state by its own definition and tradition is to serve the causes of justice, the common well being." Presbyterian Church (U.S.A.) 200th General Assembly Minutes, Part I (1988) p. 47.

In the most ancient of sacred teachings, this special concern was addressed to the orphan, the widow, and the alien, who at that time were among the poorest and most vulnerable. Some of these teachings enjoin the population from mistreating or oppressing the orphan, the widow or the alien (Exodus 22:21-24, Deuteronomy 24:17-21; Zechariah 7:8-10). Some teachings promote positive acts on behalf of poor and vulnerable people. Those with fields or grape arbors are commanded to leave a portion for the poor and vulnerable (Deuteronomy 14:28-29, 15:7-11, 26:12). Jesus equates faithfulness with feeding the hungry, giving drink to the thirsty, welcoming strangers, healing the sick, and visiting the imprisoned, when he says, "whatever you did for the least of these my brothers and sisters of mine, you did for me." (Matthew 25:37-40). Similarly, Muslims, as one of their five obligations, are to give alms for the poor, the needy, the workers who collect them, and those burdened by unexpected expenses. (The Holy Qur'an 9:60). Thus, acts on behalf of the needy and vulnerable, whether volunteered as individuals or commanded by society, formed the framework of the understanding of right and wrong in the history of Judaism, Christianity, and Islam.

These teachings regarding the moral imperative to provide assistance to the poor and the needy are addressed not only to individuals, but to societies and governments—requiring not only individual charity, but also social justice. These teachings extend not only to the food and property of the poor, but also their health care. Addressing the failure of Israel's government, the prophet Ezekiel (34:4) makes his accusation: "You have not strengthened the weak, you have not healed the sick, you have not bound up the injured." The prophet Jeremiah (8:22) echoes that accusation with a question: "Why, then, has the health of my poor people not been restored?"

Out of such teachings, common to this country's faith traditions, diverse faith communities created in 2011 an "Interfaith Statement of Principles: Protecting Medicaid and Medicare," which they forwarded to President Obama and Members of Congress to affirm their commitment to Medicaid as a program that serves the poor and vulnerable. The principles affirmed that:

> all individuals, regardless of their age, income, gender, gender identity, sexual orientation, race or ethnicity, geography, employment status, or health status, deserve equal access to quality, affordable, inclusive and accountable health care. Reducing health care options for some based on any of these factors is profoundly unjust . . . concern for the most vulnerable in our community, particularly low-income women, men and children and people with disabilities, is at the heart of our sacred texts and an affirmation of our common humanity.[4]

Medicaid—and its expansion through the ACA—embraces these principles and applies them to a national program that incentivizes the cooperation of states. Because Medicaid is an act of social responsibility, it is important to contrast it with acts of individual kindness. Individual acts of kindness to persons suffering ill health are commendable, but they cannot replace a nation-wide safety-net program like Medicaid, which currently serves millions of this country's poor and vulnerable. Imagining that the matter could be addressed voluntarily by faith communities or other non-governmental entities also poses equitable concerns because voluntary acts conform to different standards or no standards at all.

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[4] The full text of this statement is reproduced for the Court's convenience in Appendix B, also *available at* http://faithfulreform.org/storage/frhc/letters/medicaid_medicare_principles.pdf.

The ACA bolsters Medicaid with nation-wide standards of care and eligibility, available at last to all low-income Americans. Comparable to the lawful establishment and administration of our nation's interstate highways, power grid, water supply, and communications systems, the ACA's Medicaid improvements and expansions help strengthen federal and state partnerships to create a seamless health care safety net that goes beyond the vagaries of mercy to the reliability of justice and fairness.

II. FAITH TEACHINGS ESTABLISHING A MORAL BASIS FOR HEALTH CARE TO THE POOR LED TO THE PASSAGE OF THE SSA, MEDICAID, AND THE ACA.

A. The SSA of 1935, Founded in a Moral Concern for the Needy, Established the Foundation on Which Subsequent Programs Have Been Built.

The moral imperative to care for the needs of the sick and the poor, advanced by the moral philosophy of *amici*, is at the foundation of the United States', and its constituent states', commitment to the Medicaid program. While our nation chose in its Constitution to eschew an established religion (U.S. Const. amend. I), many of those persons who formed this nation, and many citizens today, are people of faith. Even Americans who do not subscribe to an organized religion have imbibed the values of the faith traditions represented by the *amici* through their families, heritage, educational institutions, or simply from the ambient American culture.

These moral teachings were the values that, on June 8, 1934, President Roosevelt invoked for a nation in the depths of the greatest depression it had known. The nation faced a crisis of immense proportions, with 18 million Americans on emergency relief and 10 million out of work. In the face of this catastrophe, President Roosevelt addressed Congress, explaining that:

> Our task of reconstruction does not require the creation of new and strange values. It is rather the finding of the way once more to known, but to some degree forgotten, ideals and values. If the means and details are in some instances new the objectives are as permanent as human nature.

Available at http://www.ssa.gov/history/fdrstmts.html #message1.

President Roosevelt appointed the Committee on Economic Security ("CES" or "the Committee") to recommend a course of action to address this crisis. In its 1935 Report, the Committee described the "ravages of probably the worst depression of all time," but also observed that even in "'normal times' . . . a large part of our population had little security." Report of the Committee on Economic Security, 1935, *available at* http://www.ssa.gov/history/reports/ces/ces5.html. In particular, the Committee recognized the financial burden that illness and accidents imposed upon lower-income Americans.

The Committee recommended a series of programs, which in turn laid the groundwork for the SSA of 1935. These programs, the Committee reported recalling Roosevelt's address, represented not:

> a change in values but rather a return to values lost in the course of our economic development and expansion. The road to these values is the way to progress. We will not rest content until we have done our utmost to move forward on that road.

Id. at 3 (quoting President Roosevelt's message to Congress of June 8, 1934).

The values that Roosevelt and the CES endorsed were grounded in moral principles advanced by the religions of *amici*. As historian Lew Daly explains:

> What distinguished Roosevelt was his "deep conviction," as he said during his fiery 1936 campaign, "that democracy cannot live without that true religion which gives a nation a sense of justice and of moral purpose." The major religious bodies stood behind him in this, despite his own rather indifferent religious life . . . No president who preceded him in the 20th century had so religious a following, or anything close to it. And none had so much support from religious leaders and particularly from Catholic thinkers.

Lew Daly, *In Search of the Common Good: The Catholic Roots of American Liberalism*, Boston Review, May/June 2007. *Available at* http://bostonreview.net/BR32.3/daly.php.

The SSA of 1935, Pub. L. No. 74-271, 49 Stat. 620 (codified at 42 U.S.C. § 301 *et seq.*), embodied these values. It also recognized, given the scale of the financial catastrophe the nation faced, that the states could do more for the poor with federal-state cooperation. Thus, Title II of the Act established the national social insurance program that we know today as Social Security, while Titles I, IV, and

X, created cooperative federal-state public welfare programs for the elderly, families with dependent children, and the blind, and Title IX created a federal-state compensation program for the unemployed. *See* Legislative History, 1935 Social Security Act, *available at* http://www.ssa.gov/history/35actinx. html.

The SSA's new cooperative federal-state programs offered states federal funding for state-administered programs to be operated under rules laid down in the SSA. The states quickly embraced the new federal-state cooperative approach to public assistance, accepting both federal money to carry out responsibilities they had previously tried to cover with state funds and the federal conditions that came with the money. By 1938 every state had established one or more of the cooperative public assistance programs. Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid*, 12 (rev. 2003). Notably, under the Act, provision of federal funding for the cash assistance programs was expressly conditioned on state compliance with the federal conditions, and funding could be withdrawn in the event of noncompliance. SSA, Pub. L. No. 74-271, §§ 4, 404, and 1004.

The SSA created a legal framework for cooperative federal-state programs that has since become the model for many American social welfare programs. Participation is voluntary, but states that wish to receive federal financial assistance to offset the costs the program must operate under a federally approved "state plan." Federal law sets minimum, mandatory requirements, but states retain great discretion to use federal matching funds to go beyond the minimum required by federal law. Many of these requirements continue to apply to the Medicaid program today. Timothy S. Jost, *Disentitlement? The Threats Facing our Public Health-Care Programs and a Rights-Based Response*, 76 (2003).

B. The Medicaid Program Builds on the Moral and Legal Foundation of the SSA.

The CES specifically recognized the costs sickness imposed on the poor:

> Illness is one of the major causes of economic insecurity which threaten people of small means in good times as in bad. In normal times from one-third to one-half of all dependency can be traced to the economic effects of illness. . . . Families with small incomes are compelled to sacrifice other essentials of decent living when serious illness strikes some member, go without needed medical care, or depend upon the gratuitous or near gratuitous services of doctors and hospitals. CES Rep. at 38-39.

While the CES did not recommend the creation of a medical assistance program, and the SSA did not provide for payment for medical care, the SSA expressly included provisions for further expansion and amendment. Specifically, Section 1104 of the original Act, "reservation of power," stated: "The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress." 42 U.S.C. § 1304.[5]

Exercising its power to amend, Congress soon began making incremental provisions for medical assistance for defined categories of individuals. The SSA Amendments of 1950 added a new federal-state cooperative program offering "medical assistance" for public assistance recipients. SSA Amendments of 1950, Pub. L. No. 81-743, 64 Stat. 477, 555. Stevens & Stevens, *Welfare Medicine in America* at 21-24. Further amendments to the SSA in 1960 authorized the Kerr-Mills program, which expanded federal matching funds for elderly recipients of cash assistance and for the first time offered federal funding for state programs for the "medically needy," elderly persons who did not meet state cash assistance eligibility requirements but who were impoverished by high medical costs. SSA Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924, 987; Stevens & Stevens, *Welfare Medicine in America* at 26-31.

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[5] This Court has repeatedly recognized Congress' authority to change the SSA at its discretion. *Bowen v. Public Agencies Opposed to Social Sec. Entrapment*, 477 U.S. 41 (1986); *Flemming v. Nestor*, 363 U.S. 603, 610-611 (1960).

These steps all led to Congress' 1965 passage of the Medicaid program, another cooperative federal-state program for "medical assistance." SSA Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286. The Medicaid program, unlike the earlier cooperative medical assistance programs, required states to provide medical assistance to all persons eligible under a SSA cash assistance program and to provide assistance of the same "amount, duration, and scope" to recipients under all programs. 79 Stat. at 344. States also were given the option to cover other aged, blind, disabled and dependent families who were not eligible for cash assistance but were "medically needy" because of high medical bills. *See* 79 Stat. at 351.

Medicaid was adopted to help those "persons who were most impoverished and who-because of their physical characteristics-were often least able to overcome the effects of poverty." *Schweiker v. Hogan*, 457

U.S. 569, 590 (1982). "Medicaid," in the words of former Senator William Roth (R-Del.), "when it serves the most vulnerable, particularly America's children, is moral. And these feelings are shared mutually by Republicans on the committee as well as Democrats." 143 Cong. Rec. S6058, S6067 (June 23, 1997). In short, Medicaid promotes the same values as the original SSA.

C. The ACA's Medicaid Expansions are Built on the Same Framework and Serve the Same Moral Purposes as the Original SSA.

As the National Health Law Program's brief documents, the Medicaid program has been expanded many times since 1965 to cover the disabled, the elderly, children, and pregnant women. Many of the eligibility expansions were optional for the states, but significant expansions were mandatory. Whenever Congress added new mandatory categories, it conditioned federal funding on covering the new category. *See Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004) ("State participation is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements."). This has been true of all federal-state Public Assistance Programs since the initial SSA of 1935 and of Medicaid since 1965, and it continues to be true today. *See, e.g.*, Resp't Br. at pp. 5-7.

As the Medicaid program has expanded, it has also evolved. The original Medicaid program was coupled mostly with cash assistance programs, with the mandatory and optional categories of eligibility tied to cash assistance eligibility categories—the aged, blind, and disabled and families with dependent children. Eligibility levels were set by the states.

Over time, however, Medicaid has been increasingly uncoupled from cash assistance. Indeed, with the end of the Aid to Families with Dependent Children program in 1997, Medicaid became a largely free-standing program, entirely separate from state cash assistance. By the 1980s, and continuing today, most recipients' eligibility is determined by criteria set by the federal government. *See* Kaiser Commission on Medicaid and the Uninsured, *Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services* (2005), *available at* http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf.

The ACA's Medicaid expansions to which the states object here are only the latest in this series of mandatory expansions to the Medicaid program. They continue the trend of prior federal expansions, extending Medicaid to a new category of recipients whose eligibility is defined by household income rather than by cash assistance eligibility. These expansions are the most recent chapter in our nation's attempt to achieve the, "security of the men women and children of the Nation . . . against misfortunes which cannot be wholly eliminated in this man-made world of ours," that President Roosevelt demanded in 1934. CES Report at 1. As Congressman Tim Ryan (D-Ohio) observed on the floor of the House, urging the passage of the ACA days before its adoption:

> We can't keep telling citizens in the wealthiest country that this globe has ever seen that we have the ability to care for you, but we can't afford it. It's time to pass this bill. We're going to do it this weekend. And we're going to look back, just like on Medicaid, Medicare, Social

> Security, and civil rights. We did the right thing, the moral thing.

156 Cong. Rec. H1691, H1695 (March 19, 2010).

III. THERE IS NO LEGAL COMPULSION FOR STATES TO PARTICIPATE IN MEDICAID AS EXPANDED BY THE ACA, ONLY A MORAL IMPERATIVE.

A. The States are Subject to the Same Moral Imperative as the Federal Government.

The values that drove the adoption of the SSA also impelled the states to cooperate with the federal government in participating in the SSA's assistance programs. The moral imperative to care for the poor and the sick speaks not only to the federal government, but also to the states—and both have responded.

There is a long tradition in the United States of state and local programs to care for the poor and needy antedating the SSA. Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* 133, 215-16 (10th ed. 1996). At first this took the form of almshouses and charity hospitals. By the time of the Roosevelt administration, however, many state and local governments had established more formal programs to provide cash assistance and emergency relief, as well as dispensaries to address the medical needs of the poor. In fact, by the time the SSA was adopted, 33 states had old age assistance programs, 45 states had mothers' pension statutes, and 24 states had pension programs for the blind. S. Rep. No. 74-628, at 4, 17, 22 (1935).

States also had medical assistance programs before the federal government, with the SSA Amendments of 1950, began helping to fund these programs. Although not all of the states participated in programs created by the 1950 Amendments or in the later Kerr-Mills program, general participation in the Medicaid program was almost immediate. By 1968, 37 states participated in the program, and most of the rest implemented programs soon thereafter. Stevens and Stevens, *Welfare Medicine in America*, at 156. Indeed, Congress had to revise the Medicaid program in 1967 to limit federal contributions for state programs because some states had raised eligibility levels so high.

Nevertheless, the states have never been required to participate in the Medicaid program. Although most states quickly joined the program once it became available, not all of them did. Arizona, for example, did not participate until 1982. Why, one might ask, did the states participate? The simple answer is that states are compelled by the same inescapable moral imperative as the federal government, and Medicaid has enabled them to meet this imperative with federal assistance.

B. Congress Has Not Improperly Coerced the States to Participate in Medicaid.

1. The Constitutionality of SSA Federal-State Programs is Well Established.

This is not the first challenge to Congress' authority to impose requirements through SSA Spending Clause programs. The SSA faced challenges immediately after its adoption. A trio of cases decided on May 24, 1937—*Helvering v. Davis*, 301 U.S. 619

(1937); *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937); and *Carmichael v. Southern Coal & Coke Co.*, 301 U.S. 495 (1937)—upheld the constitutionality of the federal Social Security program and the new federal-state cooperative unemployment program.

In *Helvering*, this Court held that Title II, the social insurance program for the elderly, neither exceeded Congress' powers under the Spending Clause nor violated the Tenth Amendment. In so holding, the Court recognized:

> The problem [of poverty among the elderly] is plainly national in area and dimensions. Moreover, laws of the separate states cannot deal with it effectively. . . . States and local governments are often lacking in the resources that are necessary to finance an adequate program of security for the aged. . . . Apart from the failure of resources, states and local governments are at times reluctant to increase so heavily the burden of taxation to be borne by their residents for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors. . . . . Only a power that is national can serve the interests of all.

301 U.S. at 644.

The Court in *Steward Machine* reached the same result. The states here cite *Steward Machine* repeatedly because it is the origin of the coercion theory that they urge on this Court, even though the Court expressly found no coercion there. The Petitioner employer in *Steward Machine* challenged Title IX of the SSA. Under Title IX, the federal government taxed employers to fund a federal unemployment compensation program, but employers could obtain a credit of up to 90 percent against the federal tax if they paid taxes into a state unemployment compensation program that met federal requirements, including a requirement that state program reserves be invested in a federal unemployment trust fund.

The Petitioner claimed that the SSA's 90 percent credit to employers on their federal unemployment tax for unemployment taxes paid to the states "coerced" the states into adopting unemployment compensation programs that complied with all of the federal requirements. Petitioner argued that employers in states that operated an independent unemployment compensation program that did not comply with federal conditions would purportedly face double taxation, paying taxes both to the federal government and to the state government to finance unemployment compensation programs. That argument is the same as the states present in this case: that their residents would face double taxation if the states opt out of Medicaid and finance their own program to fund health care for the poor.

The Court in *Steward Machine* began its analysis by considering the moral purpose served by the SSA. 301 U.S. at 586-89. Again, the Court recognized that the nation faced a national crisis that could not be solved by the states acting alone, not only because of the scope of the resources needed, but also because any state that imposed taxes to fund the program would lose employers to states that failed to do so. 301 U.S. at 588. The federal law essentially solved this dilemma.

Turning its attention to the coercion issue, the Court observed:

> The difficulty with the petitioner's contention is that it confuses motive with coercion. . . . *[T]o hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties.* . . . Till now the law has been guided by a robust common sense which assumes the freedom of the will as a working hypothesis in the solution of its problems. Nothing in the case suggests the exertion of a power akin to undue influence, *if we assume that such a concept can ever be applied with fitness to the relations between state and nation*. Even on that assumption the location of the point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, of fact. (emphasis added).

301 U.S. at 589-90.

In the third 1937 case, *Southern Coal & Coke* challenged Alabama's unemployment compensation law enacted pursuant to the SSA, and thus indirectly challenged the SSA itself. The Petitioner again claimed the SSA was coercive, and this Court again rejected the claim, citing *Steward Machine's* conclusion that:

> . . . the Social Security Act has no such coercive effect. . . . The United States and the State of Alabama are not alien governments. They coexist within the same territory. Unemployment within it is their common concern. Together the two statutes now before us embody a cooperative legislative effort by state and national governments for carrying out a public

> purpose common to both, which neither could fully achieve without the cooperation of the other. The Constitution does not prohibit such cooperation.

301 U.S. at 526. The Court further observed that the state legislature was free to repeal the state statute and to withdraw from the federal program at any time. *Id.*

This Court recognized in all three cases that the SSA's federal-state programs were cooperative programs, established as our nation's response to the "call of the distressed" prompted by the "disaster" of unemployment to breadwinners and their dependents, and grounded in "social and moral" as well as "fiscal and economic" foundations. *Steward Machine*, 301 U.S. at 587. The federal and state governments engaged in the programs as free actors, acting only under moral, not legal, compulsion. The states had addressed the problem of poverty on their own before the SSA, and were free to do so again, but the SSA allowed them to fulfill the moral imperative with assistance from the federal government.

2. Petitioners' Coercion Arguments Fail.

(a) The Minimum Coverage Requirement Does Not Support Petitioners' Coercion Argument.

The Medicaid program, as the states note, has grown to be one of the federal and state governments' largest programs. Expansions in the Medicaid program have often been welcomed and supported by the states. Colleen M. Grogan and Vernon K. Smith, *From Charity Care to Medicaid: Governors, States, and the Transformation of American Health Care*, in

A Legacy of Innovation, Governors and Public Policy, 204, 216-18 (Ethan G. Sribnick, ed. 2008). Nevertheless, states have brought a number of legal challenges to the program, claiming, as the states do here, that the importance of the Medicaid program coerces their participation. The appellate courts have repeatedly rejected these claims, noting that states may choose whether or not to participate in Medicaid. *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997); *Oklahoma v. Schweiker*, 655 F.2d 401, 413-414 (D.C. Cir. 1981); *Padavan v. United States*, 82 F.3d 23, 28-29 (2d Cir. 1996), *West Virginia v. U.S. Dep't of Health & Human Servs.*, 289 F.3d 281, 294-95 (4th Cir. 2002). States are required to comply with the conditions imposed by the Medicaid program, including the adult program expansion requirement, only if they choose to participate in Medicaid. States retain, as *Steward Machine* observed, the free will not to participate. The only compulsion they face to participate is moral.

The states nevertheless contend that the ACA extensions are different from earlier coverage extensions. First, the states claim that the minimum coverage requirement (I.R.C. § 5000A) "requires Medicaid-eligible individuals to obtain and maintain insurance." Pet'rs' Br. at 11. Through this requirement, the states claim, the federal government forces states to cover the Medicaid expansions to permit their low-income residents to comply with the minimum requirement. But Petitioners' effort to distinguish the ACA from earlier amendments is greatly overstated, if not erroneous. In fact, the penalty provisions that enforce the minimum coverage requirement exempt virtually all persons eligible for Medicaid who cannot obtain health insurance through their employment from any sanctions for failing to be insured.[6]

Second, the states claim that the ACA makes no alternative provision for financing health care for persons with household incomes below 100 percent of poverty, and thus forces states to expand Medicaid. But the ACA does not force states to provide health care for this population. Federal law has never required the states to provide health care for the poor. It has simply said, since 1950, that if states wish to provide health care for the poor through a federally defined program, the federal government will help. It is, again, the moral law that compels the states to provide for the poor, not the federal law.

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[6] IRC § 5000A(e)(2) exempts from the penalty all persons with incomes below the income tax filing limit (currently $9,350 per individual and $18,700 per couple). IRC § 5000A(e)(1) further exempts every household that cannot purchase a "bronze" health insurance policy (basically a very high cost sharing policy) for less than eight percent of modified adjusted gross income. The Congressional Budget Office estimates that in 2016, a bronze level policy will cost about $4,500 to $5,000 per individual and $12,000 to $12,500 per family. Letter from Douglas W. Elmendorf, Director, CBO, to Sen. Olympia Snowe, (Jan. 11, 2010) *available at* http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf. An individual purchasing non-group coverage would have to earn at least $62,500 and a family $156,250—far more than the eligibility levels of the Medicaid expansions—before becoming subject to the penalty. IRC § 5000A(e)(1) does impose penalties on individuals who can secure health insurance through their employer if the employee's share of the premium costs 8 percent or less of modified adjusted household income. This would no doubt include some persons who would be eligible for Medicaid with income under 133 percent of the federal poverty level ($14,856 for an individual and $30,657 for a family of four in 2012). *See* Families USA, 2012 Annual Federal Poverty Guidelines, *available at* http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html. Most Medicaid-eligible persons, however, would not be subject to the penalty.

(b) The ACA's Generous Funding, Even With Conditions And No Tax Credits for States that Opt Out, Does Not Amount To Coercion.

Of course, Congress makes a generous offer to states that choose to expand Medicaid coverage. The ACA offers to cover 100 percent of the costs of the expansion coverage for the first three years, phasing down its share of the cost of coverage thereafter to 90 percent by 2020. This is far more than the matching rate customarily granted for Medicaid. Given the fact that states already cover some of the medical costs of the expansion population, many states are likely to save money rather than incur additional costs, even when the coverage expansions are fully implemented. January Angeles, Center on Budget & Policy Priorities, *Health Reform is a Good Deal for the States* (Jun. 18, 2010), *available at* http://www.cbpp.org/files/4-26-10health.pdf. The fact that Congress makes a generous offer, however, does not mean that the states must accept it. Again, the only compulsion they face is the "cry of the distressed," not the force of federal law.[7]

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[7] Furthermore, as the Eleventh Circuit noted below (*see Florida v. United States Dept. of Health and Human Servs.*, 648 F.3d 1235, 1268 (2011)), the statute contradicts the states' claim that they face mandatory loss of all funds if they fail to comply. 42 U.S.C. § 1396c provides ample agency discretion both in whether, and how much, a reduction in federal benefits may result. Thus, the states' allegation of legal compulsion is illusory for this reason alone.

Petitioners appear to recognize that they have a need to provide health care to their citizens and argue that federal funding is important, if not essential, to their fulfilling this need. As discussed below, their argument that the amount of federal funding at stake is so substantial that a choice to give up that funding without a commensurate tax credit leaves them no choice at all misses the mark. Moreover, the assumption that states will be unable to meet these needs without federal assistance is questionable.

The states have no automatic right to the federal funds; the federal government could terminate the Medicaid program today and, subject to resolving outstanding claims, would owe no tax dollars, as funding or credits, to the Petitioner states. It is axiomatic that the federal government would have an absolute right to maintain federal taxes (albeit relabeled) at existing levels and use revenue previously directed to health programs for the poor for other purposes. U.S. Const. art. I, § 8, cl. 1. The Petitioners would have no claim against the federal government in that event.

Along a similar vein, this Court had occasion to hold that tax credits, let alone federal funding, is not due and owing to a state when the state-level choices (which in this case would involve opting not to fulfill the conditions of Medicaid) cause a differential or adverse impact on an individual state. *See State of Florida v. Mellon*, 273 U.S. 12, 17 (1927) (noting "Congress cannot accommodate its legislation to the conflicting or dissimilar laws of the several states, nor control the diverse conditions to be found in the various states, which necessarily work unlike results from the enforcement of the same tax."). It does not follow, therefore, that the Petitioners can legitimately claim legal coercion here where what they are really claiming is nothing more than a right to existing Medicaid funding levels for partial participation in the program or a right to a tax credit for opting out of the program. In the absence of this right, a coercion theory is wholly inapplicable and the Court need not evaluate the difficulty of the choice states must make under the ACA with respect to Medicaid.

Even so, it should not be presumed that states are incapable of providing for their residents with medical need without federal assistance. States vary widely on what they spend currently per resident on Medicaid. In 2008, for example, New York spent $9,056 per resident on Medicaid; Florida spent slightly more than half as much, $4,573. Kaiser Family Foundation, *Medicaid Payments per Enrollee*, FY 2008, *available at* http://www.statehealthfacts.org/comparemaptable.jsp?typ=4&ind=183&cat=4&sub=47&sortc=6&o=a. This was true even though New York covered 50 percent of its Medicaid costs from state funds while Florida covered only 43 percent of its costs. Kaiser Family Foundation, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, *available at* http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4. Many states currently provide health care for their lower-income uninsured residents who do not qualify for Medicaid through safety net programs and medical assistance programs, and they could continue to do so if they chose to opt out of Medicaid.

The Petitioner states, of course, are not asking to opt-out of the Medicaid program. They simply want the program to offer them a menu of optional benefits with no strings attached. Petitioners assert that their participation in Medicaid is, for purposes of a

Spending Clause analysis, subject to contract principles. Pet'rs' Br. at 26-27.[8] Although the states argue that the ACA's Medicaid expansion is unique in some way, it is, as noted above, no different from earlier Medicaid expansions, with which states must also comply as a condition of receiving any Medicaid funding.

Indeed, if this Court strikes down the requirement that states cover adults with incomes below 133 percent of the federal poverty level, it could also strike down requirements that states cover pregnant women and children up to age 5 with incomes below 133 percent of poverty, 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(2)(A)(ii); children age 5–18 with incomes up to 100 percent of poverty, 1396a(a)(10)(A)(i)(VII), 1396a(l)(2)(C); or Medicare cost-sharing for beneficiaries with incomes below 120 percent of poverty. 42 U.S.C. §1396a(a)(10)(E)(iv). Medicaid would simply become an assortment of optional programs. As noted in other *amicus* briefs in opposition to the states' claim, many other conditional federal programs would become subject to challenge as well, including many poverty, community development, education, and civil rights programs that are very important to our communities. Under such a decision, the relationship between the federal and state governments, recognized at least since May 24, 1937, would be at an end, and serious doubts would be raised about the federal government's authority to allocate taxpayer funds as it sees fit.

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[8] Petitioners then ignore inconvenient contract principles that require them to abide by the bargain they struck when the states voluntarily agreed to participate in Medicaid, thereby receiving for decades generous funding from the federal government, subject to Congress' ongoing ability to amend Medicaid unilaterally.

CONCLUSION

In the 1930s this country faced an unprecedented crisis of poverty and unemployment. Congress and the states rose to the occasion, adopting the SSA and implementing public welfare programs for the aged, blind, and dependent children across the nation. Today the nation faces another great challenge—providing basic health care for almost one sixth of the nation's uninsured population. The ACA rises to this challenge.

Nothing in the ACA requires states to participate in this expansion. The states resist simply withdrawing from Medicaid, however, because state legislators understand that they are subject to a greater law than the ACA—a moral imperative to care for the poor and the sick. The ACA broadens our nation's understanding of the moral imperative that has long grounded SSA programs. It brings us closer to the moral vision of our faith communities—a vision that recognizes the needs of all of those who cannot afford health care, not just those who fit into particular categorical pigeon holes. It does so within the limits of, and as an expression of, the United States Constitution's declaration that promotion of the general welfare is an essential purpose of legislation. The moral vision of American faith communities has been a proper and necessary consideration in legislative approaches to promoting the general welfare from the nation's inception. *Amici* urge this Court not to reject Congress' most recent response to the "call of the distressed." Like the district court and the court of appeals, this Court should uphold the constitutionality of the Affordable Care Act's Medicaid expansion.

Respectfully submitted,

THOMAS W. COONS
Counsel of Record
CHARLES M. ENGLISH
WENDY M. YOVIENE
OBER, KALER,
GRIMES & SHRIVER
A Professional Corporation
1401 H Street, N.W.
Fifth Floor
Washington, D.C. 20005
(202) 408 8400
twcoons@ober.com

February 17, 2012

APPENDIX

APPENDIX A

A FAITH-INSPIRED VISION OF HEALTH CARE

As people of faith, we envision a society where each person is afforded health, wholeness, and human dignity. That vision embraces a system of health care that is inclusive . . . accessible . . . affordable . . . and accountable.

Vision ~ Inclusive: Health care is a shared responsibility that is grounded in our common humanity. In the bonds of our human family, we are created to be equal. We are guided by a divine will to treat each person with dignity and to live together as an inclusive community. Affirming our commitment to the common good, we acknowledge our enduring responsibility to care for one another. As we recognize that society is whole only when we care for the most vulnerable among us, we are led to discern the human right to health care and wholeness. Therefore, we are called to act with compassion by sharing our abundant health care resources with everyone.

Vision ~ Affordable: Health care must contribute to the common good by being affordable for individuals, families and society as a whole. We believe that in the sacred act of creation we are endowed with the talents, wisdom and abundant resources necessary to meet the needs of one another, including the health care needs of all. Therefore, in our calling to be faithful stewards, we understand our responsibility to use our health care resources effectively, to administer them efficiently, and to distribute them with equity.

Vision ~ Accessible: All persons should have access to health services that provide necessary care and contribute to wellness. We believe humanity is sacred and that all persons should benefit from those actions which contribute to our health and wholeness. Therefore, we are called to act with justice and love, to ensure that all of us have access to the health care we need in order to live out the fullness of our potential both as individuals and as contributing members of our society. We must work together to identify and overcome all barriers to and disparities in such care.

Vision ~ Accountable: Our health care system must be accountable, offering a quality, equitable and sustainable means of keeping us healthy as individuals and as a community. We believe that as spiritual and sacred vessels, we are responsible for the care of our bodies to the best of our ability and for the care of one another regardless of individual circumstances. Therefore, individuals, families, governments, businesses, and the faith community are called to work in partnership for a system that ensures fully-informed, timely, quality and safe care that treats body, mind and spirit.

Developed by Faithful Reform in Health Care, signed by nearly 200 national, state, regional, and local faith organizations, and thousands of individuals. Delivered to the President and Members of Congress at numerous times by organizations and individuals 2009-2011.

APPENDIX B

Interfaith Statement of Principles: Protecting Medicaid and Medicare

Our organizations, as well as people of faith throughout our society, strongly support Medicaid and Medicare. In the faith community, we are often the first to witness need and distress from all causes. As providers of services and care, both physical and spiritual, our members, congregations and institutions, including religiously affiliated health care providers, are very familiar with the importance of Medicaid and Medicare.

We fully recognize that:

- Medicaid is the only program that provides comprehensive health coverage to low-income women, men, and children, the elderly, and people with disabilities. Medicaid's reach into every aspect of health care at every stage of life is remarkable, from the program's role in paying for nearly 40% of all live births to its role in funding the long-term care of seven out of 10 nursing home residents.
- Medicare is the primary source of health insurance for our nation's seniors. Coupled with Medicaid for seniors with low incomes, Medicare ensures that our seniors receive the health care they need.

In deliberations about how we address the competing priorities and needs of all those who live in the United States, we call upon our elected leaders to consider the following shared interfaith principles which inform our support for Medicaid and Medicare:

- As people of faith, we envision a society where each person is afforded health, wholeness and human dignity.
- All individuals, regardless of their age, income, gender, gender identity, sexual orientation, race or ethnicity, geography, employment status, or health status, deserve equal access to quality, affordable, inclusive and accountable health care. Reducing health care options for some based on any of these factors is profoundly unjust.
- The social safety net and its key components, including health care, must be maintained to reflect our shared commitment to protecting vulnerable populations.
- Concern for the most vulnerable in our community, particularly low-income women, men and children and people with disabilities, is at the heart of our sacred texts and an affirmation of our common humanity.
- Caring for our elders and treating them with dignity demonstrates the value we place on our enduring responsibility to enable all persons to live out the fullness of their days.

Together, Medicaid and Medicare address these principles and help fulfill our moral obligation to meet the needs of the most vulnerable members of our society. Inasmuch as the above principles guide our organizations and the millions of people of faith we represent in our support for Medicaid and Medicare, we urge our elected leaders to consider these principles in their discussions about the future of these life-saving programs.

Developed by the Washington Interreligious Staff Community Health Care Working Group and Faithful Reform in Health Care, signed by 60+ national, state, and regional faith organizations and delivered to the President and Members of Congress in 2011.

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, et al.,
Petitioners,

v.

KATHLEEN SEBELIUS, Secretary of Health and
Human Services, et al.,
Respondents.

STATE OF FLORIDA, et al.,
Petitioners,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Respondents.

*On Writs of Certiorari to the United States
Court of Appeals for the Eleventh Circuit*

BRIEF OF THE FAMILY RESEARCH COUNCIL AND 27 MEMBERS OF THE U.S. HOUSE OF REPRESENTATIVES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS AND REVERSAL ON THE ISSUE OF SEVERABILITY

KENNETH A. KLUKOWSKI
FAMILY RESEARCH
COUNCIL
801 G Street N.W.
Washington, D.C. 20001
(202) 637-4617
kklukowski@frc.org

NELSON LUND
Counsel of Record
GEORGE MASON UNIVERSITY
SCHOOL OF LAW
3301 Fairfax Drive
Arlington, Virginia 22201
(703) 993-8045
nlund@gmu.edu

Attorneys for Amici Curiae

January 6, 2012

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTION PRESENTED

Whether the Patient Protection and Affordable Care Act must be invalidated in its entirety because it is nonseverable from the individual mandate that exceeds Congress' limited and enumerated powers under the Constitution.

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INTEREST OF *AMICI CURIAE*[1]

The Family Research Council ("FRC") is a 501(c)(3) nonprofit public-policy organization headquartered in Washington, D.C., which exists to develop and analyze governmental policies that affect families in the United States. Founded in 1983, FRC advocates policy enactments that protect and strengthen family rights and autonomy, and assists in legal challenges of governmental actions detrimental to family interests.

Various provisions of the Patient Protection and Affordable Care Act are contrary to family interests. These provisions—and regulations enacted pursuant thereto—impair family autonomy regarding health care choices, coerce individual decisionmaking, fund abortions, and make health care less affordable for families. These interests are central to FRC's mission, and will be fully vindicated only by holding the Act unconstitutional in its entirety.

Remaining *amici curiae* are Members of the House of Representatives in the United States Congress seeking complete invalidation of the Act, each of whom represents constituents whose interests are implicated by the issues presented in this case. Those Members are listed alphabetically in the Appendix to this brief.

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[1] Nelson Lund and Kenneth A. Klukowski authored this brief for *amici curiae*. No counsel for any party authored this brief in whole or in part and no one apart from *amici curiae* made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this brief, and were timely notified.

SUMMARY OF ARGUMENT

If the Court finds that the individual mandate in the Patient Protection and Affordable Care Act is unconstitutional, as *amici* believe it is, the Court should invalidate the entire statute. The Court's well established severability doctrine has one fundamental principle: effectuating congressional intent. Both the text of the statute and its legislative history make it evident that Congress would not have enacted the package of legislative provisions that remain after the individual mandate is excised.

The Court's precedents show that a presumption of severability exists only where Congress has included a severability clause in the statute. No such clause can be found in this Act, and the omission was no accident. The bill passed by the House of Representatives included a severability clause, and the Senate chose not to include it in the bill that was eventually enacted.

Because the Act does not include a severability clause, congressional intent must be ascertained using the normal technique of statutory interpretation: close attention to the statutory language, to the relationships among the various provisions of the statute, and to the legislative history. In this case, all of these indicia of congressional intent point in exactly the same direction. The individual mandate is the linchpin of the Act, and the congressional objectives cannot be achieved once that linchpin is removed.

Nor can the Court possibly identify which individual provisions, if any, would have been enacted independently of the individual mandate. In addition to the complex and interrelated balance of policies in the Act, the statute became law only because of a fragile legislative bargain resulting from aggressive logrolling in the Senate.

The indicia of congressional intent on the severability issue are so clear as to be dispositive. In addition, however, the principle of judicial restraint counsels in favor of invalidating the entire statute. What is left after excision of the individual mandate is not a text that was ever passed by Congress or presented to the President. Any judicial attempt to salvage some fragments of this Act will invade the legislative domain and create a "law" that was enacted without the formalities required by Article I of the Constitution. When Congress returns to the subject of health care reform, as it inevitably must, it is going to face challenges aplenty without having to figure out how to fix a law it never voted for.

ARGUMENT

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [collectively, "ACA" or "the Act"] contains one or more unconstitutional provisions, including at a minimum the individual mandate provision.[2] Faced with a statute that is unconstitutional in part, courts must decide which of the statute's remaining provisions—if any—may be given effect. Beginning with its earliest cases, this Court has consistently regarded the resolution of this question as a matter of faithfully effectuating the legislature's intent. *See, e.g.*, Robert L. Stern, *Separability and Separability Clauses in the Supreme Court*, 51 Harv. L. Rev. 76, 106 (1937). Notwithstanding some confusion among the lower courts, and notably in the opinion of the court below, this Court has never abandoned the fundamental principle that has guided its severability jurisprudence for well over a hundred years. In this case, fidelity to congressional intent requires that the ACA be invalidated in its entirety.

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[2] Congress's purposes and findings regarding the individual mandate are set out in ACA § 1501(a), 42 U.S.C. § 18091. The statutory command that non-exempt citizens purchase federally-approved forms of health insurance beginning in 2014, and suffer a penalty for noncompliance, is set out in ACA § 1501(b), 26 U.S.C. § 5000A.

I. No presumption of severability applies in this case.

A. A presumption of severability applies only when Congress has established one by enacting a severability clause.

At one time it was common for the Court to find that unconstitutional provisions were nonseverable. *See id.* at 107-09 (collecting cases). This may have reflected a sense that leaving part of a statute in place is in tension with the bicameralism and presentment requirements of Article I. *See* U.S. Const. art. I, § 7, cl. 2. Both Houses of Congress presented the President with a specific text, and courts would justifiably be reluctant to assume that a fragment of this text would have been enacted without the invalid provisions.[3] Early in the twentieth century, Congress began including clauses specifying that invalid provisions should be treated as severable. Stern, *supra*, at 115-16. Although such clauses do not resolve all severability questions, they do help to protect courts from inadvertently intruding on the legislative function. Not surprisingly, with the increased use of severability clauses, there have been relatively fewer cases in which unconstitutional provisions have been found to be nonseverable. *See, e.g.*, John C. Nagle, *Severability*, 72 N.C. L. Rev. 203, 220-21 (1993); *see also Schiavo ex rel. Schindler v. Schiavo*, 404 F.3d 1270, 1275 (11th Cir. 2005) (Birch, J., specially concurring) ("In most cases where unconstitutional sections of a statute have been severed the legislation has contained a severability clause.").

The leading modern case, *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678 (1987), reviewed the precedents and provided a summary of the law. The key principle is that the "relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress. . . . The final test . . . is the traditional one: the unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted." *Id.* at 685 (footnote omitted).

This inquiry can be "elusive," *INS v. Chadha*, 462 U.S. 919, 932 (1983), but it is "eased" when the statute includes a severability clause because such a clause "creates a presumption that Congress did not intend the validity of the statute in question to depend on the validity of the constitutionally offensive provision," *Alaska Airlines*, 480 U.S. at 686.[4] The presumption created by a severability clause obviously cannot exist in a case involving a statute without a severability clause,[5] let alone in a case dealing with a statute, like the ACA, where Congress deliberately removed a severability clause during the legislative process.[6] In the absence of such a clause, courts must recur to the standard technique for ascertaining the intent of Congress: carefully looking at what is found "in the language and structure of the [statute] and in its legislative history." *Id.* at 687.

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[3] *Cf.*, *e.g.*, *Carter v. Carter Coal Co.*, 298 U.S. 238, 312 (1936); *Williams v. Standard Oil Co.*, 278 U.S. 235, 241-42 (1929); *Trade-Mark Cases*, 100 U.S. 82, 99 (1879).

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[4] This presumption can sometimes be overcome, as in cases where "the balance of the legislation is incapable of functioning independently" and would have to be judicially rewritten in order to operate at all. *Alaska Airlines*, 480 U.S. at 684 (citation omitted).

[5] To create something implies that it did not already exist. *See* Kenneth A. Klukowski, *Severability Doctrine: How Much of a Statute Should Federal Courts Invalidate?*, 16 Tex. Rev. L. & Pol. 1, 88 (2011). *Alaska Airlines* also noted that "[i]n the absence of a severability clause, however, Congress' silence is just that—silence—and does not raise a presumption against severability." 480 U.S. at 686 (citations omitted).

[6] The version of the ACA that initially passed the House of Representatives included a severability clause. *See* H.R. 3962, 111th Cong. § 255 (2009) (as passed by House, Nov. 7, 2009). After receiving and considering this bill, the Senate substituted a revised bill that did not include such a clause, and that bill was eventually enacted. *See* H.R. 3590, 111th Cong. (2009) (as passed by Senate, Dec. 24, 2009). This can only be regarded as a deliberate choice by Congress to reject the inclusion of a severability clause, and this choice implies that Congress did not intend to create a presumption of severability.

The court below dismissed this legislative history on the authority of congressional drafting manuals, which counsel that a severability clause is unnecessary except when the drafter wants to guarantee that a provision will be held nonseverable.

The Court recently reaffirmed that it will not sustain a statute's otherwise valid provisions when "it is evident that the Legislature would not have enacted those provisions . . . independently of that which is [invalid]." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (quoting *Alaska Airlines*, 480 U.S. at 684) (internal quotation marks omitted) (brackets in the original). When confronting a statute with a constitutional flaw, the Court does try "to limit the solution to the problem," and seeks to avoid rewriting the statute or unnecessarily invalidating the statute as a whole. *Id.* (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328-29 (2006)). This formulation cannot be read as a rejection of the established focus on congressional intent, for the *Free Enterprise* Court emphasized that "*nothing* in the statute's text or historical context makes it 'evident' that Congress, faced with the limitations imposed by the Constitution,

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U.S. Pet. App. 175a. That a severability clause may often prove to be unnecessary, however, does not imply that such clauses are meaningless or that they are mere superfluities. And the congressional drafting manuals certainly do not say or imply that the deliberate *removal* of a severability clause during the legislative process cannot be evidence of congressional intent. The court below nonetheless concluded that the removal of the severability clause during the legislative process in this case "has no probative impact on the severability question before us." *Id.* at 176a. That conclusion was mistaken.

would have preferred no Board at all to a Board whose members are removable at will." 130 S. Ct. at 3162 (emphasis added) (citations to *Alaska Airlines* and *Ayotte* omitted).

The *Free Enterprise* Court looked at the text and historical context and found *nothing* to suggest that the unconstitutional removal provision was intended to be nonseverable. What the Court did *not* do was look in those sources and then disregard indicia of congressional intent because they were somehow insufficient to overcome a judicially created presumption of severability. And for good reason: no such presumption exists. Neither *Free Enterprise* nor any other decision of this Court has created a license to reject or discount evidence of congressional intent in the text of the statute and in its legislative history.

Now, as always, severability is "essentially an inquiry into legislative intent," *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999) (citation omitted), and that inquiry proceeds on a case-by-case basis. Applying this principle to an Executive Order, for example, the Court studied the entire Order and concluded that the President intended it to stand or fall as a whole. *Id.* at 191-95.[7] Similarly, invalid campaign contribution limits have not been severed from others that might have remained fully operative when it was impossible to "foresee which of many different possible ways the legislature might respond to the constitutional objections we have found."

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[7] The Court assumed without deciding that severability principles apply to Executive Orders in the same way that they apply to legislation. 526 U.S. at 191.

Randall v. Sorrell, 548 U.S. 230, 262 (2006) (plurality opinion).

The reasoning in *Randall* has deep roots in the Court's severability jurisprudence:

> It remains to inquire whether it is plain that Congress would have enacted the legislation [without its constitutionally infirm provisions]. . . . If we are satisfied that it would not, or that the matter is in such doubt that we are unable to say what Congress would have done omitting the unconstitutional feature, then the statute must fall.

El Paso & Ne. Ry. Co. v. Gutierrez, 215 U.S. 87, 97 (1909) (citations omitted).

The fundamental principle reaffirmed in *Alaska Airlines* and many other cases—effectuating congressional intent—applies in all severability cases, though its application is sometimes heavily influenced by the presumption created by a severability clause. But even when a statute does contain a severability clause, and even when the only issue is an unconstitutional application of an otherwise valid statutory provision, the Court has emphasized that the presumption created by the severability clause can be overcome by evidence that the "legislators preferred no statute at all" to one in which the unconstitutional application must be barred. *Ayotte*, 546 U.S. at 331.

With a statute that lacks a severability clause (and *a fortiori* with a statute like the ACA, from which such a clause was removed during the legislative process), indicia of congressional intent must be found in the language and structure of the text, in the legislative history, and in the nature of the relationship among the effects the legislature intended various provisions to have. That inquiry must be conducted like any other exercise in statutory interpretation, and there is no independent or background presumption of severability in the law established by this Court.

B. This Court has not cryptically established a presumption of severability through its use of the word "evident."

In *Alaska Airlines*, 480 U.S. at 684, the Court noted that it has repeatedly said that it will refuse to sever an unconstitutional provision when it is "evident" that Congress would not have enacted the other provisions in the statute:

> The standard for determining the severability of an unconstitutional provision is well established: "'Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law.'" *Buckley* v. *Valeo,* 424 U. S. 1, 108 (1976) *(per curiam),* quoting *Champlin Refining Co.* v. *Corporation Comm'n of Oklahoma,* 286 U. S. 210, 234 (1932). Accord: *Regan* v. *Time, Inc.,* 468 U. S. [641,] 653 [(1984) (plurality opinion)]; *INS v. Chadha,* 462 U. S., at 931-932; *United States v. Jackson,* 390 U. S. 570, 585 (1968).

The word "evident" *cannot* mean indubitable, certain, or conclusive.[8] What it *can* mean, and in this context does mean, is "seeming or apparent."[9] This Court apparently first used the word in the context of severability in *Huntington v. Worthen*, 120 U.S. 97, 102 (1887):

> It is only when different clauses of an act are so dependent upon each other that it is evident the legislature would not have enacted one of them without the other—as when the two things provided are necessary parts of one system—that the whole act will fall with the invalidity of one clause. When there is no such connection and dependency, the act will stand, though different parts of it are rejected.

Here the Court presents two alternatives: one where mutual connection and dependency make it evident that different clauses were meant to stand or fall together, and one where there is *no* such connection and dependency.[10] The logical relation between these alternatives shows that the Court's focus was on the nature of the mutual connection and dependency, not on creating anything like a presumption of severability.

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[8] The word could have been used in such senses as recently as the seventeenth century, but these usages are now obsolete. 5 *Oxford English Dictionary* 470 (2d ed. 1989).

[9] *Oxford Modern English Dictionary* 363 (1992); *see also American Heritage Dictionary of the English Language* 455 (1969) (usage note under the word "evident": "*Evident* and *apparent* are often interchangeable and imply the presence of visible signs or circumstances that make the thing in question clear to the eye, or, by inference, to the mind.").

[10] The logical relation between the two alternatives presented by *Huntington* makes it clear that the Court was not suggesting that courts should sever any provisions that are capable of operating

Huntington, moreover, was echoing in slightly different words what the Court had said only a few years earlier in *Allen v. City of Louisiana*, 103 U.S. 80, 83-84 (1881) (emphases added):

> It is an elementary principle that the same statute may be in part constitutional and in part unconstitutional, and that if the parts are wholly independent of each other, that which is constitutional may stand while that which is unconstitutional will be rejected. "But," as was said by Chief Justice Shaw, in *Warren* v. *Mayor and Aldermen of Charlestown* (2 Gray ([68] Mass.), 84[, 98-99 (1854)]), "if they are so mutually connected with and dependent on each other, as conditions, considerations, or compensations for each other *as to warrant a belief* that the legislature intended them as a whole, and that, if all could not be carried into

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independently. (The reference to two things being "necessary parts of one system" was offered by the Court only as an example.) Here, as always, the test is whether the connection and dependency between provisions is such that the legislature would not have enacted one without the other. The connection and dependency might be technical in nature, but it need not be. The requisite connection might have to do with the relation between the provisions in serving the legislature's purpose, or it might even be entirely political, as when different provisions were essential elements of what *Alaska Airlines* called "the original legislative bargain." *See* 480 U.S. at 685.

> effect, the legislature would not pass the residue independently, and some parts are unconstitutional, all the provisions which are thus dependent, conditional, or connected must fall with them." The point to be determined in all such cases is whether the unconstitutional provisions are so connected with the general scope of the law as to make it impossible, if they are stricken out, to give effect to *what appears to have been* the intent of the legislature.

When *Huntington* used the word "evident," it was apparently using it to mean what *Allen* conveyed with the words "as to warrant a belief" and "what appears to have been." That is consistent with normal English usage of the word "evident," and inconsistent with an interpretation of the word that would create a presumption of severability.

When *Alaska Airlines* used the word "evident," 480 U.S. at 684, the Court cited five decisions in support of its summary of existing law. None of those decisions indicates that a presumption of severability should be applied to a statute that lacks a severability clause.

- *Buckley v. Valeo* specifically said that "[o]ur discussion of 'what is left' leaves *no doubt* that the value of public financing is not dependent on the existence of a generally applicable expenditure limit." 424 U.S. at 109 (emphasis added).

- *Champlin* was a case in which Congress had included a severability clause in the statute. 286 U.S. at 235.

- The plurality opinion in *Regan v. Time* does refer to a presumption of severability, but this is not a statement of the Court and it has no foundation in any of the majority opinions cited by the plurality. The plurality, moreover, went on to say (on the same page cited in *Alaska Airlines*) that "we are *quite sure* that the policies Congress sought to advance by enacting § 504 can be effectuated even though the purpose requirement is unenforceable." 468 U.S. at 653 (emphasis added).

- Like *Champlin*, *Chadha* involved a statute that included a severability clause, which was specifically referenced in the passage from *Chadha* cited in *Alaska Airlines*. *See* 462 U.S. at 931-32.

- Without referring to any presumption, *Jackson* analyzed the statute at issue in the case and concluded that "it is *quite inconceivable* that the Congress which decided to authorize capital punishment in aggravated kidnapping cases would have chosen to discard the entire statute if informed that it could not include the death penalty clause now before us." 390 U.S. at 586 (emphasis added).

In sum, *Alaska Airlines* used the word "evident" consistently with normal usage and with the way the word had repeatedly been used by the Court in previous opinions. The word creates no presumption of severability. Nor does it detract from the Court's acknowledged obligation to ask whether what is left of a statute after the excision of an unconstitutional provision would have been enacted by Congress.

II. Invalidation of the individual mandate provision of the ACA requires invalidation of the entire Act.

The primary purpose of the ACA was to restructure the health care and health care insurance industries so as to effect a significant expansion of insurance coverage to previously uninsured segments of the population and a significant lowering of health care costs due to economies of scale resulting from this expansion of coverage. The text of the statute itself says as much. *See* ACA § 1501(a)(2)(C), 42 U.S.C. § 18091(a)(2)(C) (individual mandate, together with the other provisions of this Act, "will increase the number and share of Americans who are insured"); *id.* § 1501(a)(2)(D), 42 U.S.C. § 18091(a)(2)(D) (individual mandate "achieves near-universal coverage"); *id.* § 1501(a)(2)(I), 42 U.S.C. § 18091(a)(2)(I) (individual mandate will "broaden the health insurance risk pool to include healthy individuals"); *id.* § 1501(a)(2)(J), 42 U.S.C. § 18091(a)(2)(J) (individual mandate, together with the other provisions of the Act, will lower health insurance premiums by increasing economies of scale).

On the day the ACA passed the House in its final form, Speaker Nancy Pelosi said the following on the House floor, summarizing the central objectives of the legislation:

> With this action tonight, with this health care reform, 32 million more Americans will have health care insurance and those who have insurance now will be spared being at the mercy of the health insurance industry with their obscene increases in premiums, their rescinding of policies at the time of illness, their cutting off

> of policies even if you have been fully paying but become sick. The list goes on and on about the health care reforms that are in this legislation: insure 32 million more people, make it more affordable for the middle class, end insurance company discrimination based on preexisting conditions, improve care and benefits under Medicare and extending Medicare's solvency for almost a decade, creating a healthier America through prevention, through wellness and innovation, create 4 million jobs in the life of the bill and doing all of that by saving the taxpayer $1.3 trillion.

156 Cong. Rec. H1896 (daily ed. Mar. 21, 2010) (statement of Rep. Pelosi).

On the eve of introducing the health care reform legislation in the House, Majority Leader Steny Hoyer explained the purpose of the Act by declaring, "This legislation will ensure peace of mind, quality care, and reliable [health insurance] coverage that can never be taken away . . . And it will bring down health care's crippling costs."[11]

In voting to adopt the bill that the President signed into law, House Assistant Democratic Leader James Clyburn explained that he was voting for this legislation because the ACA is "landmark legislation that enacts the toughest insurance reforms in history, reduces the cost of health care [and has other desirable effects]."[12]

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[11] Hoyer Statement on Introduction of America's Affordable Health Choices Act, July 13, 2009, *available at* http://hoyer.house.gov/index.php?option=com_content&task=view&id=1718&Itemid=50.

After the Senate passed the version of the ACA that was later signed into law, the Chairmen of the three House committees with jurisdiction issued a joint statement saying: "Both bills [i.e. the bill passed by the Senate and the somewhat different bill passed earlier by the House] will slow the growth of out-of-control health care costs . . . [and] make unprecedented reforms to the insurance industry to hold insurers accountable and protect consumers from delays or denials based on pre-existing conditions, from rescissions, and from exorbitant out-of-pocket expenses . . . ."[13]

Senate Majority Leader Harry Reid says on his official website: "This reform will not only lower costs, but improve choices, competition and offer more assistance to ensure that all Americans can afford health insurance."[14] When the individual mandate takes effect, Reid adds, the "Act ensures a competitive insurance marketplace where millions of Americans and small businesses will be able to purchase affordable coverage . . . ."[15] Reid further says the ACA "will help families that can't afford insurance, individuals facing discrimination for pre-existing conditions and small businesses that have been unable to offer health benefits to their employees."[16]

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[12] Clyburn Floor Statement on Historic Health Insurance Reform Legislation, Mar. 21, 2010, *available at* http://clyburn.house.gov/press-release/clyburn-floor-statement-historic-health-insurance-reform-legislation.

[13] Press Release, Congressmen George Miller, Charles B. Rangel, and Henry A. Waxman, Dec. 24, 2009, *available at* http://rangel.house.gov/news/press-releases/2009/12/rangel-senate-vote-brings-health-reform-closer-to-reality.shtml.

[14] Harry Reid Senate Website, Issues, Health Care, http://www.reid.senate.gov/issues/healthcare.cfm.

These statements by congressional leaders, and others that could be cited, vividly confirm what the text of the statute makes clear. The central objective of the ACA was to broaden insurance coverage and reduce health care costs. Stripped of essential provisions that Congress believed necessary for accomplishing those objectives, the residue of the ACA cannot operate in the manner intended by the legislature.

A. At an absolute minimum, the preexisting conditions provisions of the ACA must fall along with the individual mandate.

The key mechanism that Congress chose to accomplish its central goal was a series of new statutory regulations forbidding insurance companies to reject applicants because of their preexisting conditions and to price their products so as not to discriminate against such applicants.[17] Congress recognized the obvious fact that these new statutory regulations, standing alone, would cause the insurance market to collapse because individuals could wait until they got sick to purchase coverage. Accordingly, Congress devised the individual mandate to address this adverse selection problem. ACA § 1501(a)(2)(I), 42 U.S.C. § 18091(a)(2)(I).

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[15] *Id.*

[16] Harry Reid Senate Website, Issues, Access to Health Care, http://www.reid.senate.gov/issues/healthinsurance.cfm.

[17] *See* ACA § 1201(2)(A)-(B), (3), 42 U.S.C. §§ 300gg-1(a), 300gg-3(a); § 1201(4), 42 U.S.C. § 300gg. The ACA does permit

The statute itself specifically says that the individual mandate "is *essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of preexisting conditions can be sold." *Id.* (emphasis added). This provision of the statute alone is sufficient to confirm that Congress did not intend for the guaranteed-issue and community-rating provisions in the statute to take effect without the individual mandate. This conclusion is so clearly compelled by the statutory language that even the Solicitor General has conceded its validity in the Government's response to the petitions for certiorari. *See* Consolidated Brief for [Federal] Respondents at 10, 31-33, Nos. 11-393, 11-400; *see also* U.S. Pet. App. 186a n.144.

B. The text of the ACA indicates that the individual mandate is the linchpin of the entire statute.

Should the Court invalidate the individual mandate, this Court must invalidate the entire ACA because that mandate is a central component of "the

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discrimination on four narrow bases, such as a person's age or tobacco use. *See* ACA § 1201(1), 42 U.S.C. § 300gg.

original legislative bargain" codified in the statute. *See Alaska Airlines*, 480 U.S. at 685.

In some cases, it is plain that a statute can serve the congressional purpose even after excision of an unconstitutional provision. In *New York v. United States*, 505 U.S. 144 (1992), for example, Congress enacted three separate and independent incentives for States to provide for the disposal of low-level radioactive waste. The Court held that one of the incentives was unconstitutional, and drew the obvious inference that the congressional objective would be served by allowing the other two incentives to remain in effect. The ACA could hardly be more different from the statute at issue in *New York v. United States*.

The individual mandate and related new insurance regulations, which even the Government concedes must stand or fall together, constitute the linchpin of Congress's effort to restructure the market for health care. This is not speculation. It is what the text of the statute says.

In six separate findings, Congress indicated that the individual mandate was intended to operate "together with the other provisions of this Act" to restructure the health care market. *See* ACA §§ 1501(a)(2)(C), (E), (F), (G), (I), (J), 42 U.S.C. §§ 18091(a)(2)(C), (E), (F), (G), (I), (J). The plain meaning of "*the* other provisions" is *all* of the other provisions, not just some of them.

The plain meaning of this statutory language is confirmed by the specific congressional findings, which are not confined to dealing with the adverse selection problem or even with the new statutory regulations that would otherwise create the adverse selection problem. Congress expected the individual mandate, "together with the other provisions of the Act," to have a broader array of effects, including an increase in both the supply and demand for health care, a reduction of administrative costs, and a decrease in health care premiums. *See id.* subsections (C), (J).

These findings recognize what would in any case be evident: The ACA is an intricately balanced effort to restructure a massive and complex sector of the economy. It was intended to work as an integrated whole, and it had as its indispensable linchpin the individual mandate and the associated new regulations of insurance policies. Pull that linchpin out, and you destroy the new structure that Congress sought to build. Congress could not have intended the flotsam of this wreckage to be treated as a seaworthy vessel, and its express textual findings make it evident that it did not intend any such thing.

The Government has actually conceded this point. In defending the individual mandate provision in the Eastern District of Virginia, Secretary Sebelius characterized the individual mandate as the "linchpin" of the statutory scheme created by the ACA. *See Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 789 (E.D. Va. 2010).[18] Excising a statutory provision that is aptly described by the Government itself as the statute's linchpin would rewrite what *Alaska Airlines* called the "original legislative bargain." 480 U.S. at 685. The individual mandate is indeed the linchpin of the ACA, and it cannot be severed without violating congressional intent.

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[18] *See also, e.g.*, Def's Mot. to Dismiss at 3, Mem. in Supp. of Def.'s Mot. for Summ. J. at 26, *Cuccinelli*, 728 F. Supp. 768 (3:10-cv-188-HEH). The Fourth Circuit subsequently dismissed Virginia's suit for lack of standing, 656 F.3d 253, 273 (4th Cir. 2011), and a petition for certiorari in that case is currently pending before this Court, No. 11-420 (U.S. Sept. 30, 2011).

C. It is impossible to identify which isolated provisions of the ACA Congress would have enacted without the individual mandate.

Once the Court decides that the individual mandate and the related insurance provisions must be invalidated, the next question is whether Congress would have enacted the remainder of the Act *as a package*. It is extremely important to recognize that the question is not whether Congress could have or might have enacted *some* of the remaining provisions. There presumably are some provisions that Congress would have enacted even without the individual mandate and the related new insurance regulations. This Court, however, has no way to ascertain which ones they are.

What we *can* ascertain is that the ACA contains provisions that certainly would *not* have been enacted except for logrolling during the legislative process. Senator Ben Nelson of Nebraska, for example, originally announced his opposition to the ACA bill.[19] Senator Nelson then met with Majority Leader Reid, and immediately afterward reversed his position, announcing that he would support the bill.[20] It became public shortly thereafter that Reid had offered to include in the ACA a subsidy for Nebraska's share of the cost of the ACA's Medicaid expansion in Nelson's home state.[21] The subsidy was included in the Act. *See* ACA § 10201(c), 124 Stat. 918.[22]

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[19] *See* Greg Hitt & Janet Adamy, *Sen. Nelson Holds Up Health Bill*, Wall St. J., Dec. 18, 2009, *available at* http://online.wsj.com/article/SB126108229914495975.html.

Similarly, after initially expressing opposition to the bill, Senator Mary Landrieu of Louisiana emerged from a meeting with Majority Leader Reid in which she was offered $300 million in federal funds for

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[20] *See Nelson Accused of Selling Vote on Health Bill for Nebraska Pay-Off*, Fox News, Dec. 20, 2009, http://www.foxnews.com/politics/2009/12/20/nelson-accused-selling-vote-health-nebraska-pay/.

[21] *See* Susan Davis, *Heat Rises on Nebraska's Nelson*, Wall St. J., Jan. 2, 2010, *available at* http://online.wsj.com/article/SB126239070215313011.html.

[22] This Medicaid subsidy for the State of Nebraska was found in H.R. 3590 § 10201, which was enacted on March 23, 2010, as the Patient Protection and Affordable Care Act § 10201(c), 124 Stat. 918. The subsidy was later repealed on March 30, 2010 by the Health Care and Education Reconciliation Act §§ 1201, 1202, 1203, 124 Stat. 1051-53. Thus unlike many other inducements to vote in favor of the ACA, this Nebraska provision is no longer in the Act as amended. It was, however, vital to the passage of the ACA.

Louisiana.[23] This, too, was included in the ACA. *See* ACA § 2006, 42 U.S.C. § 1396d(aa).[24]

There are at least three other examples as well. Senator Bill Nelson suggested that he would not have voted for the bill had it not contained his amendment subsidizing 800,000 senior citizens who participate in Medicare Advantage in his home state of Florida.[25] *See* ACA § 3602, 42 U.S.C. § 1395w-21 note. Senator Chris Dodd received $100 million in federal funds intended for a university hospital in his home state of Connecticut.[26] *See* ACA § 10502, 124 Stat. 1003.[27]

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[23] *See* Gail Russell Chaddock, *Healthcare's dealbreakers: Mary Landrieu likes her $300 million*, Christian Sci. Monitor, Nov. 24, 2009, http://www.csmonitor.com/USA/Politics/2009/1124/healthcares-dealbreakers-mary-landrieu-likes-her-300-million.

[24] This section provides the additional funds for any State which "the President has declared a major disaster" area within the past "7 fiscal years." ACA § 2006(2), 124 Stat. 285. Louisiana was the only State that met this criterion.

[25] *See Senator Nelson's Statement on Thursday's Health Care Vote*, WCTV.com, Dec. 24, 2009, http://www.wctv.tv/news/headlines/80056362.html.

[26] *See* Editorial, *Health bill deals just business as usual*, Athens Banner-Herald, Dec. 23, 2009, *available at* http://onlineathens.com/stories/122309/opi_538645002.shtml.

[27] This $100 million appropriation was for a hospital that is "affiliated with an academic health center at a public research university . . . that contains a State's sole public academic medical and dental school." ACA § 10502(a), 124 Stat. 1003. Senator Dodd engineered the provision with the expectation that the funds would go to the University of Connecticut, and publicly said that he was "terribly disappointed" when the grant later went to Ohio State University months after the ACA was enacted. *See* Arielle

Moreover, Senator Max Baucus secured additional Medicare funding for asbestos-related illnesses from mining operations in his home state of Montana. *See* ACA § 10323, 42 U.S.C. § 1395rr-1.

Indeed, Majority Leader Reid openly acknowledged that he built a carefully balanced package with just enough votes to pass, and that he was systematically including financial inducements to add one vote at a time to reach the necessary 60 votes to invoke cloture. Reid publicly stated, "I don't know if there's a senator that doesn't have something in this bill that was important to them. . . And if they don't have something in it important to them, then it's—doesn't speak well of them. That's what this legislation is about: It's the art of compromise."[28]

These home-state incentives were pivotal to passage of the ACA. The vote to invoke cloture on this legislation in the Senate succeeded by a single vote.[29] Due to a public outcry, the Nebraska Medicaid subsidy was later repealed, *see* 124 Stat. 1051-53, and is not in the amended ACA now before the Court. But the

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Levin Becker, *UConn misses out on $100 million federal hospital grant*, Conn. Mirror, Dec. 29, 2010, *available at* http://ctmirror.org/story/8840/uconn-misses-out-100-million-federal-hospital-grant.

[28] David Welna, *On Health Bill, Reid Proves The Ultimate Deal Maker*, National Public Radio, Dec. 23, 2009, http://www.npr.org/templates/story/story.php?storyId=121791736.

[29] *See* Rec. Vote 395, U.S. Senate, 111th Congress, 1st Sess. Dec. 23, 2009 (invoking cloture on H.R. 3590 by a 60-39 vote), http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00395.

others remain. *See* ACA §§ 2006, 3602, 10323, 42 U.S.C. §§ 1395rr-1, w-21, 1396d(aa). It is evident that preserving such provisions would frustrate congressional intent by retaining provisions whose inclusion in the statute was so clearly predicated on enacting a package whose linchpin has been judicially excised. Doing so would turn the application of this Court's established severability doctrine on its head.

The legislative history simply confirms what the text of the Act makes clear: What is left of the ACA after the excision of the individual mandate and related new insurance regulations would never have passed Congress, and this residue does not constitute a coherent whole that Congress would have believed capable of accomplishing the legislature's objective. Because the ACA minus the individual mandate, or minus the mandate and the related new statutory insurance regulations, does not constitute a legislative package that would have been enacted, the entire statute must be struck down.

III. Judicial restraint requires that the entire ACA be struck down.

The Court's willingness to enforce statutes from which an unconstitutional provision has been excised rests on questionable constitutional foundations. The fragment of the statute that remains after an excision is not a text that was adopted by both Houses of Congress and presented to the President. At the very least, the practice of severing unconstitutional provisions is in considerable tension with the Court's disapproval of something like a line-item veto in *Clinton v. City of New York*, 524 U.S. 417 (1998). Congress may not authorize the President to excise a statutory provision while leaving the remainder of the statute in effect, *id.* at 437-39, but Congress may authorize the courts to excise a statutory provision while leaving the remainder in effect. At the very least, this creates a puzzle that the Court has not addressed.[30]

It may be too late for the Court to rethink its existing severability jurisprudence. But it is not too late to recognize that a finding of nonseverability is the more constitutionally cautious approach. Whenever the Court severs an unconstitutional provision, it leaves in place a statute that did not pass through the rigorous formalities of Article I, Section 7, and it runs a real risk of creating a law that would not have been adopted in compliance with those formalities.

That risk is significantly reduced when Congress includes a severability clause, and there no doubt are some cases in which it really is quite evident that Congress would have enacted the same statute without the unconstitutional provision. *See, e.g.*, *New York v. United States*. The ACA, however, is not such a statute. If anything, it is clear beyond doubt that Congress would *not* have enacted what is left after the individual mandate is removed, or what is left after the mandate and the inseparably related insurance regulations are removed. At the very least, it is "evident" that the surviving fragments do not constitute a legislative package that Congress would have adopted.

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[30] *See generally* Tom Campbell, *Severability of Statutes*, 62 Hastings L.J. 1495 (2011).

It would be a grave mistake to adopt the Eleventh Circuit's misguided understanding of judicial restraint, according to which the individual mandate is mere jetsam that can safely be tossed overboard because the remaining provisions are technically capable of operating as law. In this context, judicial restraint does not mean doing as little as possible, or salvaging as much as technically possible of what is left when the individual mandate is gone. What judicial restraint does require is judicial caution lest the nation find itself subject to an incoherent statute that was never enacted by Congress, and that Congress in no way ever indicated that it would have enacted.

Without the individual mandate, the ACA cannot "function in a *manner* consistent with the intent of Congress." *Alaska Airlines*, 480 U.S. at 685. What is left after the removal of that provision would not accomplish Congress's objective, and cannot operate in the manner Congress intended. Accordingly, this mutilated leftover should not be treated as though it were a law. When Congress returns to the subject of health care reform, as it inevitably must, it should not be forced to clean up after a "statute" that was effectively enacted by a misguided application of judicial severability doctrine. The legislature is going to face challenges aplenty without having to fix a law it never voted for.

CONCLUSION

If this Court finds that the individual mandate is unconstitutional, the Court should also hold that the entire statute must be invalidated, reversing the judgment of the Court of Appeals for the Eleventh Circuit in relevant part.

Respectfully submitted,

NELSON LUND
Counsel of Record
GEORGE MASON UNIVERSITY
SCHOOL OF LAW
3301 Fairfax Drive
Arlington, Virginia 22201
(703) 993-8045
nlund@gmu.edu

KENNETH A. KLUKOWSKI
FAMILY RESEARCH COUNCIL
801 G Street N.W.
Washington, D.C. 20001
(202) 637-4617
kklukowski@frc.org

Attorneys for Amici Curiae

January 6, 2012

APPENDIX

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Appendix A: List of Members of the House of Representatives in the Congress of the United States joining this brief as *amici curiae* 1a

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APPENDIX A

A total of 27 Members of the House of Representatives in the Congress of the United States have joined this brief as *amici curiae*. These Members of Congress are the Honorable:

Rep. Michele Bachmann of the 6th District of Minnesota

Rep. Spencer Bachus of the 6th District of Alabama

Rep. Diane Black of the 6th District of Tennessee

Rep. Charles Boustany, M.D., of the 7th District of Louisiana

Rep. Dan Burton of the 5th District of Indiana

Rep. Tom Cole of the 4th District of Oklahoma

Rep. John Culberson of the 7th District of Texas

Rep. Mike Fitzpatrick of the 8th District of Pennsylvania

Rep. John Fleming, M.D., of the 4th District of Louisiana

Rep. Trent Franks of the 2nd District of Arizona
Chairman, Subcommittee on the Constitution

Rep. Louis Gohmert of the 1st District of Texas
Former Judge

Rep. Tom Graves of the 9th District of Georgia

Rep. Vicky Hartzler of the 4th District of Missouri

Rep. Tim Huelskamp of the 1st District of Kansas

Rep. Jim Jordan of the 4th District of Ohio

Rep. Mike Kelly of the 3rd District of Pennsylvania

Rep. Steve King of the 5th District of Iowa

Rep. Raul Labrador of the 1st District of Idaho

Rep. Jeff Landry of the 3rd District of Louisiana

Rep. James Lankford of the 5th District of Oklahoma

Rep. Mick Mulvaney of the 5th District of South Carolina

Rep. Stevan Pearce of the 2nd District of New Mexico

Rep. Mike Pence of the 6th District of Indiana

Rep. Ed Royce of the 40th District of California

Rep. Steve Scalise of the 1st District of Louisiana

Rep. Jean Schmidt of the 2nd District of Ohio

Rep. Lamar Smith of the 21st District of Texas
Chairman, House Committee on the Judiciary

AMICUS
CURIAE
BRIEF

No. 11-400

In The
Supreme Court of the United States

◆

STATE OF FLORIDA, *et al.*,

Petitioners,

v.

DEPARTMENT OF HEALTH AND
HUMAN SERVICES, *et al.*,

Respondents.

◆

**On Writ Of Certiorari To The
United States Court Of Appeals
For The Eleventh Circuit**

◆

BRIEF OF *AMICI CURIAE* HEALTH LAW & POLICY SCHOLARS AND PRESCRIPTION POLICY CHOICES IN SUPPORT OF RESPONDENTS ON THE CONSTITUTIONAL VALIDITY OF THE MEDICAID EXPANSION

◆

MICHAEL KEVIN OUTTERSON (*Counsel of Record*)
BOSTON UNIVERSITY SCHOOL OF LAW
765 Commonwealth Avenue
Boston, MA 02215
(617) 353-3103
mko@bu.edu

LAURA HERMER, UNIVERSITY OF TEXAS*
NICOLE HUBERFELD, UNIVERSITY OF KENTUCKY
ELIZABETH WEEKS LEONARD, UNIVERSITY OF GEORGIA
SARA ROSENBAUM, GEORGE WASHINGTON UNIVERSITY
SIDNEY D. WATSON, SAINT LOUIS UNIVERSITY
Counsel for Amici

(*All institutional affiliations are
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Jesse A. Goldner, Saint Louis University
Michele Bratcher Goodwin, University of Minnesota
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Richard S. Saver, University of North Carolina
Stacey Tovino, University of Nevada, Las Vegas
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Diana R. H. Winters, Boston University
Ruqaiijah A. Yearby, Case Western Reserve University

QUESTION PRESENTED

The Medicaid expansion in Section 2001(a)(1)(C) of the Patient Protection and Affordable Care Act is one part of Congress's comprehensive effort to expand access to health care coverage. This expansion is not revolutionary, but builds on many prior statutory amendments to Medicaid. Nor does it alter the voluntary nature of the Medicaid program – as before, States remain free to decline federal funding. The Petitioners and their *amici* have mischaracterized the expansion to obscure these facts, hoping this Court will unravel this hard-fought legislative enactment.

The question presented is whether Congress may offer States generous additional funding for Medicaid, with spending conditions that entirely satisfy the four-part test in *South Dakota v. Dole*, 483 U.S. 203 (1987).

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INTEREST OF *AMICI CURIAE*[1]

Health Law & Policy Scholars are scholars who study and teach health law and policy in the United States. We seek to correct the factual record on the history and expansion of the Medicaid program, and thus to place this litigation in its proper context. The Medicaid expansion in the Patient Protection and Affordable Care Act is not revolutionary by any standard but is a step-wise extension, built on programs from various State laboratories of democracy over the years. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

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◆

STATEMENT

Medicaid is a cooperative federal-state program. States choosing to participate must submit a State plan for approval by the Secretary of Health and Human Services. While Medicaid gives States some discretion in designing and administering their programs, since 1965 federal law has imposed numerous mandatory requirements, including categories of individuals and families who must be covered, services that States must provide, and requirements for administering the program. *Harris v. McRae*, 448 U.S. 297, 301 (1980) ("Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of [the Medicaid Act]."); 42 U.S.C. 1396a(a)(10).

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[1] This brief is submitted with the consent of the parties, as lodged with the Clerk per the Docket Sheets. Pursuant to Rule 37.6, counsel represent that this brief was not authored in whole or in part by counsel for any party. *Amici* have borne their own expenses, without support from any party. The Boston University School of Law provided *pro bono* assistance.

Congress enacted Section 2001(a)(1)(C) of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (ACA or Act),[2] to expand the Medicaid program, creating a new mandatory category of eligibility that States must cover beginning January 1, 2014. ACA §2001(a)(1)(C). This category includes children and adults under 65 with incomes up to 133% of the federal poverty level (FPL) who are not pregnant, eligible for Medicare, or otherwise eligible through another mandatory Medicaid category. *Id.* Petitioners' constitutional challenge focuses on this particular provision. States' Br. 7-8. Petitioners do not challenge any optional Medicaid features of the ACA, see, *e.g.*, ACA §2001(a)(4) (giving states an option to cover those with incomes up to 133% FPL prior to 2014); ACA §2401 (community first option to cover attendant-care services for those at risk of institutionalization). Neither do they challenge new mandatory administrative requirements for reporting adult quality of care for Medicaid enrollees, ACA §2701; major modifications to Medicaid drug coverage, ACA §§2501-2503; or increased primary care payment rates in Medicaid, ACA §1202 (as amended).

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[2] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

Petitioners claim that ACA §2001(a)(1)(C) is an "extreme and unprecedented abuse," changing the fundamental nature of Medicaid. States' Br. 23. But imposing new Medicaid mandatory provisions on States as part of a national health policy agenda is not unusual. Medicaid was enacted in 1965 as part of a suite of Social Security Act amendments that also created Medicare to provide health insurance for elderly retired workers. Since the beginning, Medicaid has been part of larger Congressional health policy programs. Also since the beginning, Medicaid has imposed mandatory eligibility, services, and administrative requirements on participating States. The ACA's inclusion of a new category of mandatory eligibility is not surprising and is in keeping with well-settled expectations.

Petitioners claim that the Act somehow radically departs from the first forty-seven years of Medicaid. States' Br. 7-8, 10-11, 23. It is nothing new, however, for Congress to enact mandatory Medicaid reforms as part of a comprehensive package addressing national health policy problems.

Petitioners give the impression that Congress has never expanded Medicaid with broader program conditions attached to State participation. States' Br. 5-6, 22. But on numerous occasions, Congress has required conditions for continued participation in the already-existing program. Congress has included mandatory Medicaid reforms – some related to eligibility, others to benefits and coverage, and still others related to payment and administration – in the mix of broader policy interventions designed to tackle problems that transcend any single solution in a pluralistic and multi-state health care system. See Kaiser Family Foundation, *Medicaid: A Timeline of Key Developments, 1965 – 2009*. Indeed, conditional Medicaid expansions to address national problems have been a hallmark of the program since its enactment. Sidney D. Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost-Shifting to Patients*, 51 St. Louis L.J. 403, 405 (2007); Sara Rosenbaum, *Medicaid*, 346 New Eng. J. Med. 635, 635 (2002). The following examples illustrate this important facet of Medicaid program history, undermining key assumptions in Petitioners' arguments about the supposedly unique constitutional injury inflicted by the Act.

A. Congress Has Previously Added New Mandatory Eligibility Categories to Medicaid

Petitioners are correct that in 1965, when Medicaid was first enacted, mandatory eligibility was typically tied to eligibility for federal-state cooperative welfare programs. States' Br. 2-3. However, beginning in 1972, Congress amended Medicaid, adding mandatory federal eligibility requirements, often as one part of broader, national health policy goals. The ACA's new mandatory category for low-income children and adults, ACA §2001(a)(1)(C), is simply the latest example in this long-standing tradition of using Medicaid mandatory categories as an instrument of national health policy to guarantee the poorest American access to affordable health insurance. Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era,* 9 J. Health Care L. & Pol'y 5, 16-22 (2006).

In 1972, Congress ended the federal-state cooperative welfare program for the aged, blind and disabled and replaced it with Supplemental Security Income (SSI). Social Security Act Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, §§201, 301. Congress revised Medicaid to reflect this new national policy and required States to either extend Medicaid to all those eligible for the new SSI program or, under the so-called 209(b) option, allow those with incomes above the State's old cooperative welfare program eligibility limits to qualify for Medicaid by deducting medical expenses from income. *Id.* §§209, 301, as amended by Pub. L. No. 93-66, 87 Stat. 152, §212 (1973); Gov't Br. 6.

Petitioners make much of the fact that the 1972 amendments allowed States two options to comply with the new national policy. States' Br. 4. Both options, however, were expansions. States did not have the option to forgo expansion entirely. Gov't Br. 5-6.

In 1988, Congress went even further, completely de-linking Medicaid eligibility for children and pregnant women from federal-state cooperative welfare programs. Congress created new mandatory eligibility categories up to 133% FPL for children from birth to age 5 and pregnant women, and up to 100% FPL for children age 6-18. See Medicare Catastrophic Coverage Act of 1988 (MCCA), §302, Pub. L. No. 100-360, 102 Stat. 683 (adding 42 U.S.C. 1396a(a)(A)(10)(i), 1396a(l)); Omnibus Budget Reconciliation Act of 1990, §4601, Pub. L. No. 101-508, 104 Stat. 1388. States were required to cover everyone in these new mandatory categories. Congress did not offer States any choice, other than leaving Medicaid entirely.

B. Congress Has Previously Expanded Mandatory Medicaid Benefit Categories as Part of Broader National Child Health Policies

In 1967, Congress reacted to two national crises: rampant poor health among preschool children and the high rate at which young draftees were failing Army physical exams. Sara Rosenbaum et al., *National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT* 6-11 (2005). In response, Congress enacted a suite of reforms aimed at strengthening the education and training of pediatric health professionals and provided direct financing to public health departments to identify, screen, and treat impoverished children and youth. Social Security Act Amendments of 1967, Title III, Pub. L. No. 90-248, 81 Stat. 821.

As part of this larger initiative, Congress dramatically expanded mandatory federal Medicaid coverage requirements, creating the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program. EPSDT required States to cover, at minimum: a comprehensive health and developmental history; a comprehensive unclothed physical exam; appropriate immunizations; laboratory tests; health education; vision, dental, and hearing services; and care needed to diagnose or treat an identified condition, even if that treatment is not otherwise available under a State's Medicaid plan. See 42 U.S.C. 1396d(r). EPSDT expanded the mandatory coverage standards for children to a level unequaled in public or private health insurance at the time. Sara Rosenbaum & Paul S. Wise, *Crossing the Medicaid-Private Insurance Divide: The Case of EPSDT*, 26 Health Affairs 382, 383-384 (2007).

Since 1967, Congress has strengthened EPSDT several times, often over political objections from some States. See Alice Sardell & Kay Johnson, *The Politics of EPSDT Policy in the 1990s: Policy Entrepreneurs, Political Streams, and Children's Health Benefits*, 76 Milbank Q. 175, 186, 190-192, 197-198 (1998); Omnibus Budget Reconciliation Act of 1989, §6403, Pub. L. No. 101-239, 103 Stat. 2106 (further delineating the scope of EPSDT benefit, including an express mandate that States cover "Such other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan"); Deficit Reduction Act of 2005, §6044, Pub. L. No. 109-171, 120 Stat. 4 (requires States to preserve EPSDT coverage in benchmark packages); Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, §611, Pub. L. No. 111-3, 123 Stat. 8 (clarifying requirement to provide EPSDT in benchmark packages); ACA, §2201 (preserving EPSDT as part of the newly reconfigured benchmarks).

C. Congress Has Previously Imposed Mandatory Medicaid Reimbursement Rules as Part of Larger Efforts to Develop and Sustain a Health Care Safety Net for Medically Underserved Communities

Nearly one-third of America's population resides in medically underserved urban and rural communities. Sara Rosenbaum et al., *National Health Reform: How Will Medically Underserved Communities Fare?*, Policy Research Brief No. 10, 3 (2009). The needs of these communities are acute. Their inhabitants tend to be sicker, poorer, and older than the general population, are more likely to either be uninsured or to have public insurance, and have diminished access to health care providers. See Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform and Rural Economies*, 113 W. Va. L. Rev. 1, 5 (2010);

Kevin Grumbach et al., *Physician Supply and Access to Care in Urban Areas*, 16 Health Affairs 71, 78-79 (1997). Although some States invested in public hospitals and local health department services, a national, systematic approach was needed to support a health care safety net. See, *e.g.*, Health Resources and Services Administration, *Designation of Medically Underserved Populations and Health Professions Shortage Areas*, 73 Fed. Reg. 11232-11281 (Feb. 29, 2008).

In response, Congress established the National Health Service Corps in 1972 and added the Community Health Centers program three years later as basic components of Public Health Service Act programs to support services to underserved communities. Sara Rosenbaum et al., *Community Health Centers in an Era of Health System Reform and Economic Downturn: Prospects and Challenges* 1-2 (2009).

As part of national policies to support these communities and the safety net providers who serve them, Congress added mandatory reimbursement and administrative requirements to Medicaid. In 1981, Congress required States to provide enhanced reimbursement to hospitals that treat a disproportionate number of uninsured and Medicaid patients. Omnibus Budget Reconciliation Act of 1981, §2173, Pub. L. No. 97-35, 95 Stat. 357; see also Theresa A. Coughlin & David Liska, *The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues* 1-2 (1997). In 1989, Congress required States to pay clinics designated as either rural health clinics or federally qualified health centers at a special, typically higher, rate. Omnibus Budget Reconciliation Act of 1989, §6404, Pub. L. No. 101-239, 103 Stat. 2106.

These mandatory Medicaid reimbursement rules are yet another example of how Congress has used Medicaid to implement national health policies. While States retain discretion to design the outer limits of their Medicaid programs, Congress repeatedly has used mandatory Medicaid requirements to define the "very core." Gov't Br. 24, 26.

D. Congress Has Previously Imposed New Mandatory Quality Standards for Long-Term Care in Medicaid as Part of Broader Safety and Quality Efforts

The quality of nursing home care became a national concern in the mid-1980s, following numerous investigations of substandard care and patient safety problems. Institute of Medicine, *Improving the Quality of Care in Nursing Homes* 3-4 (1986). Because the financial base of the nursing home industry rests substantially on Medicare and Medicaid, Congress used these programs to reshape nursing home quality. In 1987, Congress enacted a detailed set of requirements addressing quality, resident safety, and residents' rights as conditions for Medicare and Medicaid certification. These conditions of participation required nursing homes to provide regular assessments of residents' functional capacities and written care plans based on these assessments; offer enumerated activities and services to residents; maintain staffing levels by qualified personnel for specified hours; give residents transfer and discharge rights; and protect residents' funds. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, §4211, 101 Stat. 1330.

In conjunction with these amendments, Congress required States to establish nurse aide competency evaluations, registries, and nursing facility administrator standards; evaluate each mentally ill or developmentally disabled resident annually to determine if they should be discharged; amend State plans to account for new federal requirements; and, most notably, conduct annual, unannounced, standardized surveys of long-term care facilities, with follow-up investigation of allegations of resident abuse and neglect. *Id.* at §§4201, 4202.

Once again, Medicaid mandatory requirements – this time mandatory requirements as to how States administer their programs – were added in the service of larger national health policy concerns.

E. Congress Has Previously Imposed New Mandatory Medicaid Requirements on States as Part of Medicare Part D Prescription Drug Coverage

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (MMA), represents another example of a national health policy problem that includes Medicaid as part of the solution. Jonathan Oberlander, *Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act*, 32 J. of Health Pol., Pol'y & L. 187, 190-191 (2007). Republican leadership in Congress supported the MMA, but it was narrowly enacted with scant support from Democrats. *Id.*

The MMA was a response to the urgent need to extend affordable prescription drug coverage to the nation's Medicare beneficiaries, including 8.9 million individuals covered by both Medicare and Medicaid (dual eligibles). Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries* 1 (2011). The Republican-led extension of the Medicare outpatient prescription drug benefit (Part D) to dual eligibles was entirely compulsory, not optional, for States.

Part D displaced each state's Medicaid prescription drug coverage program for dual eligibles. MMA §103. The legislation eliminated state options concerning Medicaid coverage of outpatient prescription drugs and established a single national program under direct federal control. Financing included compulsory State contributions (known as the "clawback") toward the cost of Part D. MMA §103. The expenditures were not nominal: the Congressional Budget Office estimated that States would pay a total of $155 billion in clawback payments to the federal government between 2007 and 2016. Cong. Budget Office, *The Budget and Economic Outlook: Fiscal Years 2007 to 2016*, at 59 (2006). In 2003, States protested the clawback, characterizing it as "an unprecedented intrusion into each State's sovereignty." *Texas v. Leavitt*, 547 U.S. 1204 (2006) (mem.) (denying original jurisdiction to States seeking an injunction against implementation of the Part D clawback); Brief of Arizona et al. as Amici Curiae In Support of Pls., *Texas*, 547 U.S. 1204 (No. 135). Nevertheless, States have now successfully adapted their Medicaid programs to Part D's requirements.

F. Conclusion

The history of the Medicaid program is long and detailed. Our purpose in this Statement is to highlight several significant mandatory expansions since 1965 that Congress has enacted as part of larger national health policies. Petitioners characterize the ACA's mandatory eligibility expansion as an "extreme and unprecedented abuse," States' Br. 23, 39-42, because it works in tandem with other health legislation to accomplish the national health policy goal of making health insurance affordable for all Americans. If the mandatory expansion in ACA §2001(a)(1)(C) is indeed coercive – as Petitioners claim – then they must articulate why no previous Medicaid expansions have been coercive. In fact, Petitioners overstate the discontinuity in the Act. As history makes clear, these changes build on prior foundations and are by no means unprecedented.

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SUMMARY OF THE ARGUMENT

The ACA's provisions expanding Medicaid eligibility are entirely consistent with the recognized scope of congressional spending power and the longstanding cooperative nature of the Medicaid program. Acknowledging that the ACA's Medicaid provisions clearly satisfy the four-part test in *South Dakota v. Dole,* 483 U.S. 203, 207-208 (1987), Petitioners now ask this Court to "fashion" new limits on the spending power. States' Br. 28, Gov't Br. 15-16. But the ACA amendments to Medicaid do not warrant a departure from established precedent and practice.

To merit novel judicial treatment of the Medicaid amendments, Petitioners must demonstrate that whatever they claim is wrong with Medicaid is entirely new and novel. As a baseline, the States' challenge cannot be understood to assert constitutional infirmity to tried and true features of the existing program. If there is a straw that breaks the camel's back, it must be constitutionally distinguishable from all previous straws in Medicaid. Petitioners fail in this task.

The federal government has for many decades used Medicaid as a tool to further larger, national health policy goals. The fundamental elements of Medicaid have long been mandatory. While unconditional block grants to States might be a political objective for some Petitioners, it would be a late moment in the history of the Republic to discover that the Constitution requires it.

Petitioners stake their entire coercion case on a single claim: that the federal government is making an offer the States cannot refuse, holding the *existing* Medicaid program hostage unless the States agree to mandatory Medicaid expansions. States' Br. 8-9, 39-42. But Petitioners do not – and cannot – point to any textual support in the ACA for their contention: each proffered text is either indistinguishable from many prior Medicaid amendments, relies on a distinction that entails no constitutional significance, or is simply misinterpreted. Furthermore, while the States claim the threatened loss of all Medicaid funding, States' Br. 10-11, 39-40, this result is anything but a foregone conclusion. Rather, any denial of federal funding rests in the reasonable discretion of the Secretary, who has *never* withdrawn all Medicaid funding for State noncompliance.

Nor should the number of Petitioners now opposed to the ACA impress this Court. Political differences over health reform policy do not equate to unconstitutional coercion of States by Congress. Or as fourth circuit judge J. Harvie Wilkinson III puts it, "[o]ur [judicial] self-control will be put to the test. The health care reform act of 2010 seems misconceived in many ways, but flawed legislation is not on that account unconstitutional." J. Harvie Wilkinson III, Cosmic Constitutional Theory: Why Americans Are Losing Their Inalienable Right to Self-Governance (in press, 2012).

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ARGUMENT

I. Congress Has Exercised Its Spending Power in a Clearly Constitutional Manner

A. The Medicaid Amendments Satisfy Existing Precedent

The Court's Spending Clause jurisprudence clearly authorizes Congress to expand Medicaid to cover low-income children and adults, and this case does not compel reconsideration of well-established precedent. Bedrock cases defining the federal spending power allow Congress to offer financial incentives to States willing to participate in federal programs and policies. States are free to refuse federal conditional funding and exercise their fiscal and administrative autonomy through their own ability to tax and spend. Petitioners are unable to cite any Supreme Court precedent supporting their arguments that the Act's Medicaid amendments violate this Court's previously recognized limits on the spending power or unconstitutionally coerce States, as evidenced by their request that the Court "fashion" limits. States' Br. 28; U.S. CONST., Art. I, § 8, cl. 1.

Precedent undergirding the Medicaid program's essential design is long-standing, unambiguous, and undisturbed. Since 1936, the Court has endorsed the general welfare clause as a separate enumerated power and has recognized Congress's authority to place conditions on both taxing and spending to influence state policy. See *United States v. Butler*, 297 U.S. 1, 66 (1936); *Steward Machine Co. v. Davis*, 301

U.S. 548, 591 (1937); see also *Helvering v. Davis*, 301 U.S. 619, 644-645 (1937). Congress relied on these precedents when amending the Social Security Act in 1965 to create Medicaid.

Two recent cases have explored limits on federal conditional spending power, and neither compels a different result for the Medicaid issue before the Court. First, in *South Dakota v. Dole*, 483 U.S. 203 (1987), the Court relied on the established reasoning in *Helvering*, *Steward Machine*, and *Butler* to set forth a four-part test for conditional spending, *id.* at 207-208. In the present case, the court of appeals noted that "[t]he state plaintiffs do not contend that the Act's Medicaid expansion violates any of these restrictions" under *Dole*. *Florida v. HHS*, 648 F.3d 1235, 1263 (11th Cir. 2011); Gov't Br. 15-16.

Dole also rejected South Dakota's push for a Tenth Amendment limitation on conditional spending, tracking the reasoning advanced by the federal government. See Brief for the United States, *Dole*, 483 U.S. 203 (No. 86-260), 1987 WL 880322, at *15-16; *cf.* Brief for South Dakota, *Dole*, 483 U.S. 203 (No. 86-260), 1987 WL 880315 at *63-71. The Court expressly rejected South Dakota's argument that the Tenth Amendment places an independent constitutional bar on conditional spending. *Dole,* 483 U.S. at 210.

The Court also noted: "Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* at 211 (quoting *Steward Machine,* 301 U.S. at 589-590). Upon this language, Petitioners hang all their hopes. Yet *Dole* provided no elaboration and did not find coercion on the facts of that case. Although *Dole* and *Steward Machine* acknowledged the theoretical possibility of a coercion claim, those statements have never been uncoupled from the Court's skepticism that coercion "can ever be applied with fitness to the relations between state and nation," *Steward Machine*, 301 U.S. at 590. As discussed in the Statement and in Section II, *infra,* these particular Medicaid amendments do not create enough "pressure" to become "compulsion." *Dole*, at 211 (quoting *Steward Machine,* 301 U.S. at 589-590).

The second decision to explore conditional spending power and reject Tenth Amendment limitations was *New York v. United States*, 505 U.S. 144 (1992), decided a few years after *Dole. New York* permitted conditional spending to "influence a State's legislative choices." *Id.* at 167, 188. Congress may "encourage a state to conform to federal policy choices" by virtue of conditional spending, and if a State's residents do not like the federal policy, they can instruct the State's legislators to reject the federal funding. *Id.* at 168. The litigants again invited judicial enforcement of Tenth Amendment limits on all congressional authority, but the Court declined the invitation and reiterated that "the Federal Government [can] hold out incentives to the States as a means of encouraging them to adopt suggested regulatory schemes." *Id.*

at 188; see also *College Savings Bank v. Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999) (describing federal spending as a "gift"). The Court has never recognized the Tenth Amendment as a separate limit on the conditional spending power, and the almost fully-funded Medicaid expansion at issue is not the occasion to do so.

Finally, the Court has consistently required that States "clearly understand" the terms of the federal funding, protecting them from unknown terms. *Arlington Central School Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006). In the present case, the Medicaid expansions were debated for many months and included a phase-in period of almost four years for States to assess the terms of the funding, more than sufficient for "clear notice." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 25 (1981).

B. The Reasoning of the Court of Appeals Below Is Sound and Is Further Supported By Five Additional Arguments

These Medicaid amendments are not the compelling case for creating new precedent that the States depict them to be, and not just for the reasons articulated by the court of appeals below. See *Florida v. HHS*, 648 F.3d at 1267-1268. At least five additional arguments support the Act's constitutionality.

First, the federal government has for many decades used Medicaid as a tool to further larger, national health policy goals. Congress has mandated the fundamental elements of Medicaid – the baseline requirements of who is eligible and what services they must receive – while allowing options that expand beyond the baselines. See Statement, *supra*. Mandatory Medicaid eligibility has been expanded several times, and although on each occasion States could have withdrawn from the program, nevertheless, they remain. *Arkansas Dep't of Health & Human Servs. v. Ahlborn,* 547 U.S. 268, 275 (2006) ("States are not required to participate in Medicaid, but all of them do.").

Second, while the States claim the threatened loss of all Medicaid funding, States' Br. 10-11, 39-40, this result is not automatic but rests in the reasonable discretion of the Secretary, who has *never* withdrawn all Medicaid funding for State noncompliance. See Brief of Former HHS Officials as Amici Curiae in Support of Respondents, *Douglas v. Indep. Living Ctr. of S. California, Inc.*, Docket Nos. 09-958, 09-1158, and 10-283, 7-8, 23-25 (2011). HHS policy is to work with States to encourage compliance rather than to penalize fragile Medicaid beneficiaries. See 42 C.F.R. 430.32 (States found to be out of compliance with federal requirements will be asked to "correct" divergent practices); 42 C.F.R. 430.35 (State funding will not be withheld until "a reasonable effort has been made to resolve the issues through conferences and discussions"). The Medicaid Act provides that "the Secretary shall notify [the] State agency that further payments will not be made to the State (*or, in his discretion, that payments will be limited to categories* *under or parts of the State plan not affected by such failure*), until the Secretary is satisfied that there will no longer be any such failure to comply." 42 U.S.C. 1396c (emphasis added); 42 C.F.R. 430.35 (indicating that HHS will resume any funding that was halted once compliance is demonstrated).

Petitioners' fear of total funding loss, States' Br. 35 n.15, 37, 39-40, is simply not cognizable, as the Secretary has never exercised this power in forty-seven years of Medicaid administration. The Secretary has not threatened these States with the loss of all funds after adoption of the ACA. See Gov't Br. 40-41. Coercion would surely require more than a theoretical fear of a never-expressed threat before the claim is ripe for constitutional adjudication. See, *e.g.*, *Poe v. Ullman*, 367 U.S. 497, 508 (1961) ("The fact that Connecticut has not chosen to press the enforcement of this statute deprives these controversies of the immediacy which is an indispensable condition of constitutional adjudication. This Court cannot be umpire to debates concerning harmless, empty shadows.").

Third, though Petitioners argue they are "locked" into participating in Medicaid, States' Br. 45 n.17, and it may be true that most States could not afford to run their own medical assistance programs absent changes in their tax laws, many steps lie between this argument and the conclusion that States are coerced into participating in Medicaid. The federal government does not coerce States simply because they lack the political will to leave Medicaid or to provide funding for similar care. These arguments speak to State behavior, not federal power. Medicaid fills a need; one that the States ceded to the federal government but could take back if desired. Courts have long held that the temptation of funding does not actually remove States' "freedom of the will," *Steward Machine*, 301 U.S. at 589-590, to make a choice and live with the consequences.

Fourth, the essence of Petitioners' argument is that when States accept vast quantities of federal funds, States should gain control over federal appropriations. In short, if States depend on Medicaid, it must be coercive. If this paradox were true, then States would have a perverse incentive to maximize federal funding and their reliance upon it to such a degree that the federal government would be forced to cede control over its appropriations to the States. While unconditional block grants to States might be a political objective for some Petitioners, it is a late moment in the history of the Republic to discover that the Constitution requires it. This perverse view turns a successful model of cooperative federalism on its head and ignores the dual nature of Our Federalism, wherein both States and the United States can exercise independent powers to tax and spend.

Fifth, federal spending legislation is the law of the land by virtue of the Supremacy Clause. Telling the federal government that it cannot set the terms of its own duly enacted conditional spending statute would be a dangerous step toward reversing the foundational, near-century-old understanding of the power to spend as a distinct enumerated power.

II. The Medicaid Amendments Are Not Coercive

Petitioners must demonstrate that whatever is wrong with Medicaid is entirely new and novel. Constitutional infirmity cannot be attached to tried and true features of the existing program. The straw that breaks the camel's back must be constitutionally distinguishable from all previous straws in Medicaid. Petitioners fail in this task.

A. Petitioners Do Not Challenge the Constitutionality of the Existing Medicaid Program

Petitioners do not claim that Medicaid itself is unconstitutional as it stood immediately before the Act. States' Br. 5; Pet'rs' Cert. Pet. 6-7. Precision is important here. Petitioners attack Medicaid with broad-brush strokes, conflating the cost of the existing Medicaid program with the new amendments. See States' Br. 39 ("The coerciveness of that demand is self-evident, as the sheer size of the federal inducement at stake puts this spending legislation in a class of one. Medicaid is already the single largest federal grant-in-aid program, accounting for a staggering 40% of all federal funds distributed to States and nearly 7% of *total* federal spending."). They make no claim that Congress's previous Medicaid amendments are in any way constitutionally invalid. To make sense of Petitioners' coercion argument, the Court must understand that their contention is limited to very specific subsections of the new Medicaid amendments in a few portions of Title II of the Act that allegedly threaten existing Medicaid funding. States' Br. 40-41.

But the existing Medicaid program is not on trial here. If anything, Petitioners profess their reliance on existing Medicaid funding. States' Br. 39-41. The cost of the existing Medicaid program is relevant – if at all – only if the federal government actually threatens to cut off all funds in order to unconstitutionally coerce the States, which it has never done since 1965 and does not threaten to do here. See Section I.B., *supra*.

B. The Optional Medicaid Amendments Are Not Coercive

Throughout the history of the Medicaid program, some coverage expansions have been mandatory while others are completely optional for States. See Statement, *supra* (describing the history of the program). The Medicaid expansions under the Act are no different. For example, ACA Section 2001(a)(4) gives States the option to expand coverage before January 1, 2014, and ACA Section 2401 gives States the option to provide certain home and community-based services. Petitioners do not challenge any optional Medicaid amendments as coercive. See Gov't Br. 53 n.24 (citing States' Br. 47-48, 50).

C. The Mandatory Medicaid Amendments Are Not Coercive

1. The Allegedly Partisan Nature of the Act Is Not Evidence of Coercion

One of Petitioners' *amici* emphasizes the partisan nature of the ACA enactment process. Br. of Center for Constitutional Jurisprudence et al. in Support of Pet'rs (Medicaid) 13-16. Although the constitutional salience of this statement is unclear, we make a few observations.

Petitioners claim to represent twenty-six States at the present moment, States' Br. ii, but when Congress voted for the ACA in March 2010, Senators or Representatives from twenty-two of the twenty-six Petitioner States voted for the Act. Kevin Outterson, *Obama Couldn't Have Done It Without You, Red State Edition*, The Incidental Economist (February 14, 2012). From the Petitioners' congressional delegations, a total of twenty-one United States Senators and eighty-eight Members of the House of Representatives voted for the Act. *Id.* Quite simply, the Act could not have passed without the support in 2010 from the Petitioners' duly elected congressional delegations. As is often the case, the political landscape changed after the mid-term elections in November 2010,[3] but that change should alert this Court to the

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[3] After the 2010 mid-term elections and after Judge Vinson had issued his substantive opinion on the motion to dismiss, 716 F. Supp. 2d 1120 (N.D. Fla. 2010), six states (Ohio, Kansas, Wyoming, Wisconsin, Maine, and Iowa) joined this suit as Petitioners

(Continued on following page)

dangerous implications of a State's *subsequent* political leadership claiming that the *former* leadership had been coerced. Shifting political winds do not imply coercion.

In addition, at least one of the Petitioners is a house divided. The Governor of Iowa is listed here as a Petitioner; meanwhile, the Attorney General of Iowa has joined two briefs in support of the Act. Br. of California et al. in Support of Resp. (Severability); Br. of Maryland et al. in Support of Pet'r (Minimum Coverage Provision). We should not assume that the Petitioners represent a monolithic consensus within their States. Politics will run their course in due time through the elected branches of our government.

2. The Mandatory Medicaid Amendments Are Not a Novel Feature of the Act

For many decades Congress has modified the Medicaid program through a combination of optional and mandatory provisions. See Statement, *supra*. Indeed, most federal spending power legislation attaches mandatory conditions to receipt of federal funds. See, *e.g.*, *South Dakota v. Dole*, 483 U.S. 203 (1987). Mandatory coverage categories are not a "transformation of Medicaid," States' Br. 38, but have been a remarkably common feature of the program for decades. See

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on January 18, 2011 through the filing of a Second Amended Complaint in the district court, N.D. Fla. Dkt. 148, despite the passing of the court's deadline for new parties to be added.

Statement, *supra* (describing mandatory Medicaid coverage categories over time). Given this historical continuity, Petitioners have failed to demonstrate why this particular set of Medicaid amendments somehow crosses a constitutionally significant line.

3. The Federal Government Bears About 95% of the Cost of the Mandatory Medicaid Amendments

The Medicaid amendments themselves are not coercive because they will cost the States little or no money. The mandatory expansions qualify for very generous federal matching (FMAP) of 100% from 2014-2016, phasing down to 90% FMAP in 2020 and thereafter. 42 U.S.C. 1396d(y). Official projections claim the Act will *save* the States $33 billion. Memorandum from Richard S. Foster, Chief Actuary, CMS, to the Obama Administration and Congress 12 (Apr. 22, 2010) ("The net impact of the Medicaid and CHIP provisions on State Medicaid costs is a reduction totaling $33 billion through fiscal year 2019."); Matthew Buettgens et al., *ACA and State Governments: Consider Savings as Well as Costs*, Urban Institute (July 2011). A state-by-state analysis by The Kaiser Commission on Medicaid and the Uninsured projected that over the coming decade, the federal government will pay for 95% of the incremental costs under the Medicaid amendments, leaving 5% of the costs ($21.1 billion) to be paid by the States. John Holahan & Irene Headen, *Medicaid Coverage and*

Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL at 2 (2010).

Other cost estimates are not germane because they are not limited to the mandatory Medicaid expansions at issue in this case. For example, some cost estimates include the enrollment of previously eligible individuals, which are not new mandatory coverage expansions. See Cong. Research Service, *Variation in Analyses of PPACA's Fiscal Impact on States* (Sept. 8, 2010). Petitioners make no claim that Medicaid before the ACA was unconstitutional. Nor have they articulated any theory explaining why it is unconstitutional to encourage enrollment of people already entitled to coverage under existing law. The cost of any optional Medicaid provisions – about 60% of Medicaid costs in 2007 – is also irrelevant to this case and cannot be a basis for a coercion claim. See Gov't Br. 4, 29-30.

The fiscal impact of the mandatory coverage expansions on the States, when paired with an exceedingly generous 95% average federal match, is so modest that the Petitioners "argument as to coercion is shown to be more rhetoric than fact." *Dole*, 483 U.S. at 211. Just as the withholding of 5% of federal highway funds could not be coercive in *Dole*, the 5% State contribution to mandatory Medicaid expansion cannot be considered coercive here.

Petitioners quibble with this in only a half-hearted way. Their primary point of contention is not with the existing Medicaid program, or the various optional and ancillary Medicaid amendments *per se*, but with the very specific provisions that allegedly threaten the loss of *existing* Medicaid funding. States' Br. 8-9, 39-42. To these arguments we now turn.

D. Petitioners Fail to Identify Any Constitutionally Infirm Text in the Mandatory Medicaid Amendments

Petitioners stake their entire coercion case on a single claim: that the federal government is making an offer the States cannot refuse, holding the *existing* Medicaid program hostage unless the States spend $21.1 billion over a decade on the mandatory Medicaid expansions. States' Br. 8-9, 39-42.

Petitioners are unaccountably vague as to the exact textual source of their troubles. See States' Br. 39 ("The ACA threatens States with loss of *all* of their federal Medicaid funding if they do not capitulate to Congress' mandate that they dramatically expand their obligations under the program."). The Petitioners offer no citation for that dramatic statement. Indeed, throughout that four-page section of their brief, no citation is made to any provision in the ACA. See States' Br. 39-42. Petitioners have yet to identify the precise language that is allegedly coercive and compels that conclusion. Petitioners obliquely suggest several candidates: (1) mandatory coverage expansion for low-income children and adults; (2) the "essential health benefits" standard; (3) the "maintenance-of-effort" rule; and (4) Section 2304. States' Br. 7-13. As we demonstrate in the sub-sections immediately following, each proffered text is either indistinguishable from many prior Medicaid amendments, relies on a distinction that entails no constitutional significance, or is simply misinterpreted.

1. Medicaid Expansion to Low-Income Children and Adults Is Constitutional

Petitioners assert that the Act is unique in extending coverage to low-income children and adults, beginning January 1, 2014. States' Br. 6-7. This provision is found in ACA Section 2001(a)(1)(C), amending 42 U.S.C. 1396a(a)(10)(A)(i)(VIII). See Statement, *supra* (discussing this coverage expansion and its historical antecedents). Petitioners do not articulate any plausible constitutional distinction between this group of children and adults and existing Medicaid beneficiaries to whom federal law already guarantees coverage.

Medicaid presently mandates coverage for seven categories of children and nonelderly adults. 42 U.S.C. 1396a(a)(10)(A)(i)(I)-(VII); see Statement, *supra*. Petitioners articulate no reason why it is suddenly unconstitutional to adopt an eighth mandatory category of low-income children and adults under the age of 65 with incomes up to 133% FPL[4] who are not pregnant women, Medicare-eligible, or in another mandatory category. The ACA's new category becomes mandatory in 2014. In the meantime, it is an optional category that States may choose to cover. See Section II.E., *infra* (describing the efforts of early-adopter States).

Petitioners may have preferred that Congress had given this population coverage through the ACA health insurance exchanges with tax subsidies, see States' Br. 35-36, but this policy disagreement does not rise to the level of a constitutional infirmity. Congress had rational reasons for choosing Medicaid: it costs less per person than private insurance and has a long and honorable track record of serving America's poorest and most vulnerable. Whether the Petitioners agree with these reasons is the realm of politics, not constitutional law.

2. The Essential Health Benefits Provision Is Constitutional

The second textual candidate – although not clearly cited by Petitioners – is the requirement that

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[4] Petitioners are concerned about the size of this Medicaid expansion, States' Br. 7-8, but do not articulate any specific constitutional infirmity with 133% FPL as a boundary, which in 2012 is an annual income of $14,856.10 for an individual in the continental United States, or $30,656.50 for a family of four. 2012 HHS Poverty Guidelines, http://aspe.hhs.gov/poverty/12poverty.shtml. Why is 100% FPL constitutional, but 133% is allegedly not?

States provide the ACA's new mandatory category of low-income children and adults with Medicaid benchmark coverage that includes the ACA's "essential health benefits" (EHB). See ACA §2001(a)(2), amending 42 U.S.C. 1396a(k)(1); ACA §2001(c), amending 42 U.S.C. 1396u-7(b)(5); and the closely related provisions describing "benchmark" coverage, *id.* While the Petitioners label this issue "minimum essential coverage," States' Br. 8, see ACA §1302, the core definition for Medicaid purposes is EHB, from which both benchmark plans and minimum essential coverage are measured. ACA §2001(c)(3), amending 42 U.S.C. 1396u-7(b)(5). Petitioners' confusion may arise from the fact that ACA §2001(a)(2) provides for the new EHB requirement and includes the phrase "minimum essential coverage" in its caption. See ACA §2001(a)(2).

Petitioners characterize the EHB changes as novel and revolutionary. States' Br. 8 ("that new and onerous requirement . . . "). As the history of Medicaid aptly demonstrates, program design has never been static, see Statement, *supra*, and mandatory coverage standards for categorically needy individuals have been a hallmark of the program since 1965. See 42 U.S.C. 1396a(a)(10)(A). Coverage changes are an annual feature of most commercial health plans and are similarly unsurprising in Medicaid. This commonplace activity does not rise to the level of unconstitutional coercion.

While the federal government has historically and constitutionally mandated minimum Medicaid coverage standards, the federal government has, in the case of the EHB, indicated an intention to delegate to the States authority to define the details of the EHB. Center for Consumer Information and Insurance Oversight, Department of Health and Human Services, *Essential Health Benefits Bulletin* at 8 (Dec. 16, 2011). For example, the definition of benchmark plans in the HHS guidance allows States to choose among several types of plans offered in the large group or small group markets, thus allowing the EHB package to vary from State to State, based on local commercial market factors. *Id.*; see also Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost* (Oct. 7, 2011). Many other decisions are also being made at the State level, such as the distinction between medical and nonmedical benefits, *id.* at 4-19 to 4-20, and the definition of "medical necessity," *id.* at 5-23 to 5-28. Therefore, Petitioners' claim that the Act "eliminates the flexibility States previously enjoyed," States' Br. 8, is unfounded and overstated. Indeed, HHS policy on implementing the ACA more broadly has reflected a commitment to "maximum flexibility" to the States in implementing the Act's cooperative programs. See, *e.g.*, U.S. Dept. of Health and Human Services, *Patient Protection and Affordable Care Act, Establishment of Exchanges and Qualified Health Plans*, 76 Fed. Reg. 41866, 41893 (July 15, 2011) (announcing regulations affording State regulators "significant flexibility" in applying standards for qualified health plans under the new State Exchanges).

Petitioners are reduced to arguing that conforming Medicaid to the same coverage standard required for many commercial insurance plans under ACA §1302 is unconstitutionally coercive, while not challenging Section 1302 itself. This is thin gruel for a coercion claim, especially when States pay so little of the incremental cost.

3. The Maintenance-of-Effort Provision Is Not Coercive

Only one subsection in the Act appears to condition *existing* FMAP on immediate compliance with a provision Petitioners find objectionable: the "maintenance-of-effort" (MOE) provision in ACA §2001(b)(2), amending 42 U.S.C. 1396a(gg); States' Br. 6, 8-9, 45 n.17; Gov't Br. 30-31. As CMS explained to States, "[t]he MOE provisions in the Affordable Care Act generally ensure that States' coverage for adults under the Medicaid program remains in place pending implementation of coverage changes that become effective in January 2014." CMS, Letter to State Medicaid Directors, Re: Maintenance of Effort 1 (Feb. 25, 2011) (*MOE Letter*).

Claims of coercion or lack of clear notice are not supportable given that HHS has used MOE provisions in many previous situations. Mark Greenberg, *HHS Policy Guidance On Maintenance of Effort, Assistance, and Penalties: Summary and Discussion*, 4 Geo. J. on Fighting Poverty 315 (1997). Indeed, the "Affordable Care Act MOE statutory provisions are very similar to the MOE provisions in section

5001(f)(1) of the American Recovery and Reinvestment Act," which were in place and to which States were subject before the ACA was passed. See *MOE Letter*, at 1.

In addition, the relevant MOE provision here is temporary, expiring State by State as exchanges are created, no later than Dec. 31, 2013.[5] ACA §2001(b)(2), codified at 42 U.S.C. 1396a(gg)(1)-(2). When States have fully operational exchanges, the relevant part of the MOE provision is effectively waived. ACA §2001(b)(2).

Finally, the MOE provision cannot support a coercion argument because States may receive a waiver of the requirement through a simple process. Petitioners complain that the mandatory expansions will directly impact their budgets, States' Br. 18, 39, but ignore ACA §2001(b)(2), amending 42 U.S.C. 1396a(gg)(3), which excuses State noncompliance with the MOE with respect to non-pregnant, non-disabled adults earning more than 133% FPL if "the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding year, the State is projected to have a budget deficit." *Id*; *MOE Letter*, at Q.5.

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[5] For children under 19, the MOE provision expires on October 1, 2019. Section 2001(b)(2), codified at 42 U.S.C. 1396a(gg)(2). Petitioners do not specifically challenge the children's eligibility rules, focusing their complaint at the expansion for low-income childless adults, States' Br. 7-8, so the relevant expiration date is no later than December 31, 2013.

At least one Petitioner has made this certification to the Secretary. On December 29, 2011, the State of Wisconsin filed the required certification. Letter from Mike Huebsch, Secretary, Wisconsin Department of Administration (Dec. 29, 2011) (attachment). Under this certification and pending an amendment to the State plan, Wisconsin will disenroll 53,161 Wisconsin residents from Medicaid. Wisconsin Department of Health Services, ***2011-2013 Medicaid Efficiencies, Maintenance of Effort (MOE) Waiver Request of Eligibility Restrictions Established Under the Patient Protection and Affordable Care Act*** (PPACA) (undated, *circa* 2011). The certification excuses Wisconsin from the MOE provision until June 30, 2013, and thereafter if Wisconsin files again. *Id*.

4. Section 2304 Is a Modest Clarification, Not a Sweeping Change

As the last arrow in their quiver, Petitioners claim "the Act requires States not only to pay the costs of care and services for Medicaid enrollees, but also to assume responsibility for providing 'the care and services themselves.'" States' Br. 9. This may sound like a commandeering claim, but it is nothing of the sort. Petitioners cite ACA Section 2304, concerning "the care and services themselves," States' Br. 9, but curiously ignore the use of the disjunctive "*or*" immediately before and "or both" immediately after their quote. The full text of Section 2304 (found not in the text, but only in their appendix, States' Br. 45a) inserts "or the care and services themselves, or both." The omitted language is significant; in fact, the omitted language entirely undermines Petitioners' ensuing argument.

The purpose of this provision was merely to clarify the long-standing meaning of "medical assistance" in Medicaid. See Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements,* 42 U.C. Davis L. Rev. 413, 453-458 (2008). The House Report makes this abundantly clear:

> Section 1905(a) of the Social Security Act defines the term "medical assistance." The term is expressly defined to refer to payment but has generally been understood to refer to both the funds provided to pay for care and services and to the care and services themselves. The Committee, which has legislative jurisdiction over Title XIX of the Social Security Act, has always understood the term to have this combined meaning. Four decades of regulations and guidance from the program's administering agency, the Department of Health and Human Services, have presumed such an understanding and the Congress has never given contrary indications.

H.R. Rep. No. 111-299, 1st Sess., at 649-650, 2009 WL 3321420, at *693-695 (Leg. Hist.) (Oct. 14, 2009); see also 156 Cong. Rec. H1854, 1856, 2010 WL 1006359 (Mar. 21, 2010) (statement of Rep. Waxman) (explaining on the House floor the committee report's rationale for the clarification); *id.* at H1891, 1967, 2010 WL 1027566 (Mar. 21, 2010); Jane Perkins & Gene Coffey, *Patient Protection Act Clarifies The Meaning of "Medical Assistance,"* National Health Law Program (March 31, 2010) (discussing the cases and legislative history). This modest clarification does not require any State to provide medical services directly.

E. The Medicaid Amendments Cannot Be Considered Coercive to Early Adopter States

ACA §2001(a)(4) allows "early adopter" States to voluntarily expand coverage prior to January 1, 2014. Minnesota, Connecticut, and Washington D.C. have taken advantage of this provision and other States, such as Massachusetts and California, have essentially become early adopters through Medicaid waivers.

The example of early adopter States advances two arguments. First, the fact that some States have eagerly expanded optional coverage years ahead of schedule undermines Petitioners' claim of coercion. Clearly, these States, and other States filing briefs supporting the Act, embrace the Medicaid amendments.

Second, States accepting these benefits should be protected from any ruling that would strike down relevant portions of the Medicaid amendments. The Petitioners, if successful on this issue, seek the freedom to reject the federal offer, but this remedy should not be imposed on other States that willingly accept the Medicaid amendments. The more appropriate remedy "would be to enjoin the 'application' of the provision to unconsenting States and otherwise to permit the eligibility extension to function as written." Gov't Br. 53 (citation omitted). Any State that wants to continue to access federal funds under the ACA should be allowed to do so, whether or not a sister State alleges coercion. Federalism is not well served by destroying the carefully crafted laws and programs that many States have built in reasonable reliance on the ACA, including the exchanges and accepting the offer of early optional expansion. Br. of California et al. in Support of Resp. (Severability), 13-27 (detailing the legislative efforts of California and other States to implement the ACA).

Connecticut was the first state to take advantage of the early adoption provision. *Connecticut First in Nation to Expand Medicaid Coverage to New Groups Under the Affordable Care Act*, U.S. Department of Health & Human Services (June 21, 2010). Connecticut expected that 45,000 adults would become Medicaid-eligible under the new expansion. *Id.*

In May 2010, the District of Columbia followed suit. Darryl Fears, *D.C. Jumps At Health-Care Savings In Expanded Medicaid*, Wash. Post, May 14, 2010, at B2. The approval of the request of the District of Columbia for the early enactment of the

Medicaid expansion meant "switch[ing] 35,000 individuals from an insurance program funded by city taxpayers to the Medicaid program." *Id.*

In January 2011, Minnesota expanded the state's Medical Assistance Program, "provid[ing] MA benefits for an estimated 51,000 adults currently enrolled in MinnesotaCare and approximately 12,000 people not enrolled in a state health care program." *Governor Dayton Expedites Medicaid Expansion*, Home Page of the Office of the Governor (Jan. 20, 2011).

Under a Medicaid Section 1115 waiver, Massachusetts has already expanded subsidized insurance coverage to the population between 100% and 133% of the FPL. Br. of Health Care For All et al. (Minimum Coverage Provision) 7. Coverage has been extended to 411,722 Massachusetts residents under its reforms. *Id.* at 9. Absent the additional federal funding through this waiver, Massachusetts could not continue its Chapter 58 health care reform initiative. *Id.* at 7. Massachusetts and CMS recently agreed on a $26.75 billion extension of this waiver for the next three years. *Governor Patrick Announces $26.75 Billion Medicaid Waiver Agreement* (Dec. 21, 2011).

California also was granted a Medicaid waiver to allow the State to transition to Medicaid expansion to take place in 2014 under the Act. California Department of Healthcare Services, *California Bridge to Reform: A Section 1115 Waiver Fact Sheet* (Nov. 2010). Though not utilizing provisions in the ACA itself, the waiver expands coverage to those individuals who will be newly eligible under the Medicaid expansion in 2014. *Id.* California has nearly seven million uninsured individuals and roughly a fifth of those individuals are expected to be covered by 2016 under the program. Kaiser Family Foundation, *California's "Bridge To Reform" Medicaid Demonstration Waiver* (Oct. 2011 Update). As with Massachusetts, California is heavily relying on these Medicaid expansions to ensure that it can afford to provide healthcare for its residents. Br. for California et al. in Support of Resp. (Severability) 28 ("Hundreds of thousands of individuals could thus face losing their health insurance.").

The clearly expressed desire of these early adopter States, which are eager to accept the federal offer to help hundreds of thousands of State residents, demonstrates that Petitioners' fear of coercion is not universally felt amongst the States. In no event should the reasonable expectations of these States, including enhanced FMAP for mandatory and optional coverage expansions, be upset by the inchoate fears of their sister States.

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CONCLUSION

The judgment of the court of appeals upholding the Medicaid eligibility expansion should be affirmed.

Respectfully submitted,

MICHAEL KEVIN OUTTERSON (*Counsel of Record*)
BOSTON UNIVERSITY SCHOOL OF LAW
765 Commonwealth Avenue
Boston, MA 02215

LAURA HERMER, UNIVERSITY OF TEXAS
NICOLE HUBERFELD, UNIVERSITY OF KENTUCKY
ELIZABETH WEEKS LEONARD, UNIVERSITY OF GEORGIA
SARA ROSENBAUM, GEORGE WASHINGTON UNIVERSITY
SIDNEY D. WATSON, SAINT LOUIS UNIVERSITY
Counsel for Amici

February 17, 2012

AMICUS
CURIAE
BRIEF

No. 11-400

In The
Supreme Court of the United States

◆

STATE OF FLORIDA, et al.,

Petitioners,

v.

DEPT. OF HEALTH AND HUMAN SERVICES, et al.,

Respondents.

◆

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

◆

BRIEF OF THE INDEPENDENCE INSTITUTE AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

MEDICAID MANDATE

◆

DAVID B. KOPEL
Counsel of Record
INDEPENDENCE INSTITUTE
727 East 16th Ave.
Denver, Colo. 80203
(303) 279-6536
david@i2i.org
Counsel for Amicus Curiae

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

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STATEMENT OF AMICUS INTEREST[1]

The Independence Institute is a public policy research organization created in 1984, and founded on the eternal truths of the Declaration of Independence. The Independence Institute has participated as an amicus or party in many constitutional cases in federal and state courts. Its amicus briefs in *District of Columbia v. Heller* and *McDonald v. Chicago* were cited in the opinions of Justices Alito, Breyer, and Stevens. McDonald v. Chicago, 130 S.Ct. 3020, 3026 n.2, 3106 n.31, 3115 (2010) (Alito, J., majority opinion; Stevens, J., dissenting); District of Columbia v. Heller, 554 U.S. 570, 700, 701, 710 (2008) (Breyer, J., dissenting) (in both cases cited under name of lead amicus International Law Enforcement Educators & Trainers Association).

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SUMMARY OF ARGUMENT

By imposing the Medicaid mandates in the Affordable Care Act ("ACA"), Congress exceeded the scope of its enumerated powers. If allowed to stand, those mandates could be the death-knell for the Constitution's finely calibrated system of federalism.

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[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation of submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission.

The states truly would be little more than agencies for Congress to "commandeer" at will.

The Founders created and the People ratified a Constitution protecting the States' role as limited "sovereigns." As this Court has ruled repeatedly, the states' sovereign "independence" entitles them to make decisions within their sphere based on their own policy judgments, free of federal coercion. As explained below, this rule and the closely-related principle of federal non-coercion is of particular constitutional importance in financing health and social services.

In sustaining the Medicaid mandates, the United States Court of Appeals for the Eleventh Circuit overlooked both Founding-Era constitutional principle and modern Supreme Court doctrine. It also overlooked aspects of the Medicaid mandates that particularly aggravate their coercive qualities. Insofar as the ACA authorizes withdrawal of all Medicaid funds from States that choose not to submit to the Medicaid mandates, that statute slashes at the heart of American federalism. It is unconstitutional and void.

ARGUMENT

I. The text of the Constitution and the debates surrounding its adoption, as duly applied by Supreme Court case law, show that although the Constitution granted sovereignty over some subjects to the federal government, the Constitution also retained the states as sovereign entities.

A. The Founders recognized that the Constitution divided sovereignty.

One of the great achievements of the constitutional settlement of 1787-1791 was division of sovereignty between a central government (as to enumerated subjects) and the states (as to other subjects). Alden v. Maine, 527 U.S. 706, 751 (1999) (opinion by Justice Kennedy, quoting several earlier holdings).

Previously, the prevailing orthodoxy had been that sovereign power was indivisible, and that to attempt to split it was to commit the fallacy of *imperium in imperio* – that is, "supreme power within supreme power." In accordance with that orthodoxy, prior governments had either been "consolidated" (lodging all sovereignty in one central authority) or "confoederal" (lodging sovereignty in provinces or states that deputized the central authority for certain purposes). *See, e.g.*, Arts. Confed., art. II ("Each state retains its sovereignty, freedom, and independence, and every power, jurisdiction, and right, which is not by this

Confederation expressly delegated to the United States, in Congress assembled.").

While the Constitution was under consideration, one source of doubts about its viability was whether a system of truly split sovereignty could operate effectively. As might have been expected, Anti-Federalists had such doubts. *See, e.g.*, The Impartial Examiner, Letter I, VA. INDEPENDENT CHRONICLE, Feb. 20, 1788, *reprinted in* 8 THE DOCUMENTARY HISTORY OF THE RATIFICATION OF THE CONSTITUTION 387, 393 (Merrill Jensen et al. eds., 1976) ["DOCUMENTARY HISTORY"] ("For the idea of two sovereignties existing within the same community is a perfect solecism."); James Monroe, *Some Observations on the Constitution*, c. May 25, 1788, *reprinted in* 9 DOCUMENTARY HISTORY, at 844, 858 ("For in government it is, as in phisicks, a maxim, that two powers cannot occupy the same space at the same time."). But even some Federalists, among them James Madison, had doubts as well. James Madison to Thomas Jefferson, Oct. 24 – Nov. 1, 1787, *reprinted in* 8 DOCUMENTARY HISTORY at 97, 100 (expressing the fear that lack of a congressional veto over state laws would create the evil of *imperia in imperio* – that is, supreme *powers* within the supreme power).

Yet the Constitution *did* create a system of split sovereignty, and that is what the courts are obliged to defend. As Justice Kennedy wrote in *Alden v. Maine*, "Although the Constitution grants broad powers to Congress, our federalism requires that Congress treat the States in a manner consistent with their status as residuary sovereigns and joint participants in the governance of the Nation." 527 U.S. at 748.

B. The constitutional text shows intent to divide sovereignty.

The sovereignty of both federal government and individual states is reflected in the text of the Constitution. The Supremacy Clause declares federal sovereignty within the scope of the enumerated powers granted by the Constitution. U.S. Const., art. VI, cl. 2 ("This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land. . . ."). Similarly, several textual provisions recognize complementary state sovereignty. Article III grants to states the same privilege of Supreme Court original jurisdiction extended to representatives of sovereign foreign governments. U.S. Const., art. III, §2, cl. 2 ("In all Cases affecting Ambassadors, other public Ministers and Consuls, and those in which a State shall be Party, the supreme Court shall have original Jurisdiction."). Likewise, the rule that each state, irrespective of population, is entitled to two Senators implicitly recognizes that the states are discrete sovereignties. *Id.*, art. I, §3, cl. 1. Indeed, the Constitutional Convention disregarded suggestions that state boundaries be redrawn to equalize population,[2] thus implying that the delegates understood they had no power to tamper with the sovereign existence of the states.

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[2] The suggestion was made by William Paterson. *See* 1 THE RECORDS OF THE FEDERAL CONVENTION OF 1787, at 178 & 251 (Max Farrand ed., 1937), but not seriously entertained.

In addition, the Constitution recognizes that states enjoy the sovereign attribute of indivisibility. Art. IV, §3, cl. 1 ("[N]o new States shall be formed or erected within the Jurisdiction of any other State; nor any State be formed by the Junction of two or more States, or parts of States, without the Consent of the Legislatures of the States concerned as well as of the Congress."). Accordingly, this Court's famous description of "an indissoluble union of indestructible states," Virginia v. West Virginia, 246 U.S. 565, 603 (1918), recognizes that both the Union and the States possess the attributes of sovereignty.

Indeed, the Constitution treats state sovereignty as having supra-constitutional status: It forbids any amendment that deprives a state without its consent of equal representation in the Senate. Art. V.

State sovereignty is confirmed by the Bill of Rights – specifically its final element, the Tenth Amendment. In accordance with Founding-Era drafting practice, the Bill concluded with rules for interpretation. ROBERT G. NATELSON, THE ORIGINAL CONSTITUTION, WHAT IT ACTUALLY SAID AND MEANT 35, 155-56 & 204 (2d ed., 2011). As an interpretive rule, the Tenth Amendment informs judges, and everyone else who takes an oath to uphold the Constitution, that the States have retained whatever residual sovereignty the People (the ultimate sovereigns) have bestowed upon the States: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States. . . ." U.S. Const., amend. X.

C. The ratification record shows intent to divide sovereignty.

Other than the constitutional text, the most important sources of evidence for the original meaning of the Constitution, and for the public understanding behind it, are the records of the Ratification-Era debates. It was then that the advocates of the Constitution convinced the people to adopt the Constitution, and did so by explicating what the proposed Constitution would and *would not* allow the federal government to do. During the ratification debates, leading advocates for the Constitution repeatedly and expressly assured the delegates to the state ratifying conventions, as well as the wider public, that the Constitution preserved much of the sovereignty of the States.

1. James Madison, Roger Sherman, and others.

Shortly after the Constitutional Convention adjourned, Pierce Butler, who had served as a delegate from South Carolina (and would later be a three-term U.S. Senator), wrote that "The powers of the General Government are so defined, as not to destroy the Sovereignty of the Individual States." Pierce Butler to Weeden Butler, Oct. 8, 1787, *reprinted in* 13

DOCUMENTARY HISTORY, *supra*, at 351, 352. In a report to the governor of Connecticut, the influential delegate Roger Sherman[3] and his fellow Connecticut delegate Oliver Ellsworth (later Chief Justice of this Court) emphasized that the new powers granted to the federal government "are specially defined, so that the particular states retain their *Sovereignty* in all other matters." *The Report of Connecticut's Delegates to the Constitutional Convention*, NEW HAVEN GAZETTE, Oct. 25, 1787, *reprinted in* 13 DOCUMENTARY HISTORY at 470, 471 (emphasis in original). Sherman repeated the same point in a letter written a few weeks later, Roger Sherman to Unknown Addressee, Dec. 8, 1787, *reprinted in* 14 DOCUMENTARY HISTORY, at 386, 387.

Responding to fears that in practice the new government might turn out to be "consolidated," the

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[3] Connecticut attorney Roger Sherman was the only person to sign all four of the great state papers of the American Founding: the Continental Association, the Declaration of Independence, the Articles of Confederation and the Constitution. Sherman served on the Committee of Five that drafted the Declaration of Independence. At the Constitutional Convention, he proposed the Connecticut Compromise (representation by population in the House, equal state representation in the Senate) that made agreement on the Constitution possible. He later served on the U.S. House Committee that created the Bill of Rights. His virtues were universally recognized by his contemporaries. Patrick Henry called him one of the three greatest men at the Constitutional Convention, while Thomas Jefferson wrote that Sherman "never said a foolish thing in his life." 3 THE NEW ENGLAND FARMER 334 (S.W. Cole & Simon Brown eds., 1851).

Constitution's advocates frequently represented to the ratifying public that the States were to remain "sovereign" within their sphere. Illustrative is the essay of Alexander White, a prominent Virginia lawyer (and later a Representative in the First Congress), who responded to "The Impartial Examiner," *supra*, by explaining that under the Constitution, "The State governments retain their sovereignty over all objects which respect their particular states only." Alexander White, WINCHESTER VA. GAZETTE, Feb. 29, 1788, *reprinted in* 8 DOCUMENTARY HISTORY, at 438, 442. To similar effect were comments such as those of "A Freeholder," VA. INDEPENDENT CHRONICLE, April 9, 1788, *reprinted in* 9 DOCUMENTARY HISTORY, at 719, 720 (referring to the states under the new Constitution as "sovereign and independent" as to their purposes).

The "Father of the Constitution" issued similar representations. In Federalist No. 39, James Madison wrote that "Each State, in ratifying the Constitution, is considered as a sovereign body, independent of all others, and only to be bound by its own voluntary act," Alexander Hamilton, John Jay & James Madison, THE FEDERALIST 197 (George W. Carey & James McClellan eds. 2001). Because federal "jurisdiction extends to certain enumerated objects only," the Constitution "leaves to the several States a residuary and inviolable sovereignty over all other objects." *Id.* at 198. Madison reiterated the point in Federalist No. 45: "[T]he States will retain, under the proposed

Constitution, a very extensive portion of active sovereignty." *Id.* at 239.

Many of the Constitution's proponents justified equal state representation in the Senate as a necessary result of reserved state sovereignty. For example, "A Democratic Federalist" (a Pennsylvania advocate for the Constitution) extolled the Senate because it was comprised of representatives of the sovereign states – unlike the British House of Lords, which merely represented hereditary aristocrats:

> The federal senate are the representatives of the sovereignties of their respective states. . . . instead of an hereditary upper house, the American Confederacy has created a body, the temporary representatives of their component sovereignties, dignified only by their being the immediate delegates and guardians of sovereign states selected from the body of the people for that purpose. . . .

A Democratic Federalist, INDEPENDENT GAZETTEER, Nov. 26, 1787, *reprinted in* 2 DOCUMENTARY HISTORY, *supra*, at 294, 296 (emphasis in original). *See also* Cassius III, VA. INDEPENDENT CHRONICLE, Apr. 23, 1788, *reprinted in* 9 DOCUMENTARY HISTORY 749, 750; Federal Farmer, Letter XI, Jan. 10, 1788, *reprinted in* 20 DOCUMENTARY HISTORY at 1011, 1012 (an Anti-Federalist conceding that Senators "represent the states, as bodies politic, sovereign to certain purposes").

2. Tench Coxe.

Particularly influential with the general public were the Federalist essays of the Philadelphia businessman Tench Coxe. Although he is not widely known today, during the ratification controversy Coxe was a leading molder of public opinion. His widely-distributed essays rivaled, perhaps exceeded, the influence of *The Federalist*. *See* FRIENDS OF THE CONSTITUTION: WRITINGS OF THE "OTHER" FEDERALISTS 1787-1788, 88 (Colleen A. Sheehan & Gary L. McDowell eds., 1998) (describing Coxe as a "leading defender" of the Constitution); JACOB COOKE, TENCH COXE AND THE EARLY REPUBLIC 111 (1978) ("Although Coxe's essays were not in the same literary league [as the *Federalist*], they perhaps were contemporaneously more influential, precisely because they were less scholarly and thus easier for most readers to follow. . . . As Madison, Rush, and other contemporaries recognized, Coxe's writings . . . contributed materially to the Constitution's adoption."). Justice William Brennan, citing one of Coxe's essays about the jurisdiction of federal courts, noted that Coxe had been "widely reprinted" during the ratification debates. Atascadero State Hospital v. Scanlon, 473 U.S. 234, 273 n.24 (1985) (Brennan, J., dissenting). Justice White described Coxe's essays as "the first major defense of the Constitution published in the United States." Nixon v. Fitzgerald, 457 U.S. 731, 773 n.14 (1982) (White, J., dissenting). Coxe went on to serve in the subcabinets of Presidents Washington, Adams, Jefferson, and Madison. *See* Stephen P. Halbrook & David

B. Kopel, *Tench Coxe and the Right to Keep and Bear Arms in the Early Republic*, 7 WM. & MARY BILL OF RIGHTS J. 347 (1999).

Coxe repeatedly emphasized the role that states would play as sovereigns in the constitutional system. He mentioned the "clear and permanent marks and lines of *separate sovereignty*, which must ever distinguish and circumscribe each of the several states, and *prevent their annihilation* by the federal government, or any of its operations." Tench Coxe, "A Freeman," Essay I, *reprinted in* FRIENDS OF THE CONSTITUTION, *supra*, at 89 (emphasis in original); Tench Coxe, *A Pennsylvanian to the New York Convention*, PA. GAZETTE, Jun. 11, 1788, *reprinted in* 2 DOCUMENTARY HISTORY at 1138, 1142 (listing some of the powers held by the states to exclusion of the federal government, and adding that the nature of the amendment process demonstrated that the states were sovereignties).[4]

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[4] Regarding the "Pennsylvanian" series, Coxe's modern biographer has written:

> The articles signed "A Pennsylvanian" were Coxe's most noteworthy contribution to the ratification debate and invite comparison to the best of the literature spawned by that controversy, including the *Federalist* essays, which Coxe approvingly quoted and to which his work was superior in its treatment of some subjects.

COOKE, *supra*, at 118.

Supreme Court jurisprudence completely agrees with this position. ***E.g.***, New York v. United States, 505 U.S. 144, 155 (1992) (protecting "the province of state sovereignty reserved by the Tenth Amendment"); Alden v. Maine, *supra*, 527 U.S. at 713 (collecting cases).

II. Inherent in "sovereignty" is the constitutional concept of "independence."

During the Founding Era, the term "sovereign" included widely-understood concepts of "dignity and essential attributes." Alden v. Maine, *supra*, 527 U.S. at 714. One attribute of sovereignty was "independence," an expression serving as a term of art whose meaning is explained in Part III, *infra*. Because independence was an attribute of sovereignty, Founding-Era writers often coupled the two words. For example, the Articles of Confederation reserved to each state its "sovereignty, freedom, and independence." Arts. Confed., art. II.

Advocates on both sides of the ratification debate accepted the close connection between sovereignty and independence, and agreed that it was essential to preserve both qualities for the States. The only dispute on the issue was how well the proposed Constitution did so. The New York Anti-Federalist "Cato" denounced the Constitution as insufficiently protecting the "sovereignty and independency" of the states. Cato, Letter II, N.Y.J., Oct. 11, 1787, *reprinted in* 13 DOCUMENTARY HISTORY at 369, 371. The

Anti-Federalist "Federal Farmer" conceded that a goal of the Constitution was for the states to be "sovereign and independent" for certain purposes. Federal Farmer, Letter XI, Jan. 10, 1788, *reprinted in* 20 DOCUMENTARY HISTORY at 1011, 1012.

Advocates of the Constitution found sufficient "independence" inherent in the states' reserved sovereignty. A Virginia Federalist writing as "A Freeholder" argued that states would remain "sovereign and independent" as to their purposes. A Freeholder, VA. INDEPENDENT CHRONICLE, April 9, 1788, *reprinted in* 9 DOCUMENTARY HISTORY at 719, 720. Another Virginia Federalist emphasized that, within their sphere, states would remain "sovereign and independent" and that "the grand object, which each state had in view, by uniting in a general government, must have been the retaining its sovereignty and independence." Cassius III, VA. INDEPENDENT CHRONICLE, Apr. 23, 1788, *reprinted in* 9 DOCUMENTARY HISTORY at 749, 750.

Similarly, Tench Coxe explained that, within their scope, state powers would be exercised *independently* of federal influence. Thus, after listing powers the states could exercise independently of the federal government, he asked, "in short where is the county in the union, or in the world, that can exercise in any instance *independent legislative, executive or judicial powers*? . . . So *independent* will the state governments remain, that their laws may, and in some instances will, be *severer* than those of the union." FRIENDS OF THE CONSTITUTION, *supra*, Letter III, at 98-99 (emphasis in original).

In Federalist No. 40, Madison wrote, "Do [the principles of the Confederation] require that, in the establishment of the Constitution, the States should be regarded as distinct and independent sovereigns? They are so regarded by the Constitution proposed." THE FEDERALIST, *supra*, at 202. Madison added:

> Do these principles . . . in fine, require that the powers of the general government should be limited, and that, beyond this limit, the States should be left in possession of their *sovereignty and independence*? We have seen that in the new government, as in the old, the general powers are limited; and that the States, in all unenumerated cases, are left in the enjoyment of their sovereign and independent jurisdiction.

Id. at 203 (emphasis added).

Thus, integral to the constitutional design of divided sovereignty is state government independence from federal coercion. As Justice Brandeis, writing for the Court, observed in Erie Railroad Co. v. Tompkins, 304 U.S. 64 (1938):

> [T]he constitution of the United States . . . recognizes and preserves the autonomy and independence of the states, – independence in their legislative and independence in their judicial departments. Supervision over either the legislative or the judicial action of the states is in no case permissible except as to

> matters by the constitution specifically authorized or delegated to the United States.

304 U.S. at 78-79. *See also* Alden v. Maine, *supra*, 527 U.S. at 754 (quoting this passage).

III. The constitutional concept of "independence" includes states' power to make policy, particularly fiscal policy, for their citizens within their sphere, free from federal coercion.

As the Court understood in *Alden, supra*, and in the passage quoted above from *Erie Railroad*, when leading Founders insisted that states would enjoy "independence" as part of their sovereignty, those Founders did *not* mean that the States would be separate from the Union in the sense that, for example, America had become independent of Great Britain. Rather, in this context "independence" was a term of art: The "independence" of a decision maker was freedom from the coercion or undue influence of others. As applied to the states, "independence" meant freedom from coercion or undue influence imposed by the central government. Robert G. Natelson, *A Reminder: The Constitutional Values of Sympathy and Independence*, 91 KY. L. J. 353, 382-86, 390-405 (2002-03). This sort of independence was inherent in what the "Federal Farmer" referred to as "the ideal equality of sovereignties." Federal Farmer, Letter XI, Jan. 10, 1788, *reprinted in* 20 DOCUMENTARY HISTORY, *supra*, at 1011, 1012.

The Founders believed that "independence" was crucial to enable the states to protect individual freedom against federal overreaching. *See, e.g.*, Curtius, Letter III, N.Y. DAILY ADVERTISER, Nov. 3, 1787, *reprinted in* 19 DOCUMENTARY HISTORY at 174, 179 (discussing the role of states in protecting against federal usurpations); The Triumphs of Reason, POUGHKEEPSIE COUNTRY J., Mar. 11, 1788, *reprinted in* 20 DOCUMENTARY HISTORY at 853, 857-58 (describing the states as rivals and counterbalances to the federal government).

More importantly for present purposes, however, "independence" embodied the power of the states to make those policy choices they deemed best suited for their own populations – a value the Founders saw as crucial to good decision-making. Natelson, *A Reminder, supra*. Some of the most thoughtful opponents of the Constitution worried that the scope of federal powers would not permit states to be sufficiently "independent" to make their own policy choices. Among these was "Brutus," one of the best of the Anti-Federalist writers and the foil for the "Publius" of *The Federalist*. Brutus, Letter V, N.Y.J., Dec. 13, 1787, *reprinted in* 19 DOCUMENTARY HISTORY at 410, 415 (arguing that the federal taxing power would leave the states insufficiently "independent," but that they would be "dependent on the will of the general legislature" and thus without "the power to conduct certain internal concerns"); *see also* Brutus, Letter VI, N.Y.J,. Dec. 27, 1787, *reprinted in id.*, at

466 (states must be "secured in their rights to manage the internal police of the respective states").

Of particular concern to Anti-Federalists was that the congressional *fiscal powers* might be construed so broadly as to fatally impair state financial integrity. "Brutus" warned:

> It is clear that the legislatures of the respective states must be altogether dependent on the will of the general legislature, for the means of supporting their government. The legislature of the United States will have a right to exhaust every source of revenue in every state . . . unless therefore we can suppose the state governments can exist without money . . . we must conclude they will exist no longer than the general legislatures choose they should. Indeed the idea of any government existing, in any respect, as an independent one, without any means of support in their own hands, is an absurdity.

Brutus, Letter V, N.Y.J., Dec. 13, 1787, at 410, 414. He added that "[T]he states should have the command of such revenues, as to answer the ends they have to obtain." Letter VI, N.Y.J., Dec. 27, 1787, *reprinted in id.*, at 466, 472-73.

Advocates of the Constitution, such as the Federalist author "Curtius," responded that the states would retain independence because the Constitution left "the local concerns of states, or the necessities of particular districts . . . under the direction of the states individually. From this beautiful arrangement, subjects so different in their nature . . . will for ever claim the unembarrassed [i.e., unobstructed] attention of men best competent to their discussion." Curtius, Letter III, N.Y. DAILY ADVERTISER, Nov. 3, 1787, *reprinted in* 19 DOCUMENTARY HISTORY at 174, 179. The Constitution's advocates further promised the public that congressional fiscal powers could not be exercised so as to bankrupt the states. Alexander Hamilton devoted an entire number of *The Federalist* to this argument. THE FEDERALIST No. 32, *supra*, at 154-57.

IV. Long-standing Supreme Court jurisprudence protects state "independence" by invalidating federal coercion of states.

The Supreme Court has long held that the States, when acting within their spheres, are entitled to independent decision making free of federal coercion. In part, this is to enable federalism to serve its role in preserving personal freedom. As this Court stated last term:

> Federalism secures the freedom of the individual. It allows States to respond, through the enactment of positive law, to the initiative of those who seek a voice in shaping the destiny of their own times without having to rely solely upon the political processes that control a remote central power. . . .
>
> Federalism also protects the liberty of all persons within a State by ensuring that

> laws enacted in excess of delegated governmental power cannot direct or control their actions. . . . By denying any one government complete jurisdiction over all the concerns of public life, federalism protects the liberty of the individual from arbitrary power. When government acts in excess of its lawful powers, that liberty is at stake.

Bond v. United States, 564 U.S. ___, 131 S.Ct. 2355, 2364 (2011). *See also* New York v. United States, *supra*, 505 U.S. at 181 (discussing the role of the state/federal division of power in preserving individual liberty).

In addition, however, federalism enables states to respond to the unique policy preferences of their own citizens. *Alden, supra*, at 750-51 (the States' "independence" ensures "the States' ability to govern in accordance with the will of their citizens.").

Supreme Court cases preserving the independence of state policymaking all serve the same ultimate purpose, but they fall into several doctrinal categories. Among the most prominent have been those protecting state sovereign immunity from federally-authorized lawsuits. *See, e.g.*, Hans v. Louisiana, 134 U.S. 1 (1890); Seminole Tribe v. Florida, 517 U.S. 44 (1996); Florida Prepaid Postsecondary Education Expense Board v. College Savings Bank, 527 U.S. 627 (1999); *Alden v. Maine, supra*; Kimel v. Florida Board of Regents, 528 U.S. 62 (2000). The holdings of such cases rest partly on the representations of leading Founders that individuals would not be permitted to sue the "sovereign" states without state consent. *See, e.g.*, 3 THE DEBATES IN THE SEVERAL STATES ON THE ADOPTION OF THE FEDERAL CONSTITUTION 555 (Jonathan Elliot ed., 2d ed. 1891) (reporting argument of future Chief Justice John Marshall);[5] Alexander Hamilton, THE FEDERALIST No. 81, *supra*, at 422.[6] When the Supreme Court disregarded the state sovereign immunity doctrine in Chisholm v. Georgia, 2 U.S. 419 (1793), Congress and the states rapidly adopted the Eleventh Amendment to restore the original understanding. *Seminole Tribe v. Florida*,

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[5] At the Virginia ratifying convention John Marshall, a strong Federalist, declared:

> I hope that no gentleman will think that a state will be called at the bar of the federal court. Is there no such case at present? Are there not many cases in which the legislature of Virginia is a party, and yet the state is not sued? It is not rational to suppose that the sovereign power should be dragged before a court.

3 THE DEBATES IN THE SEVERAL STATES, *supra*, at 555.

[6] Hamilton wrote:

> . . . I shall take occasion to mention here a supposition which has excited some alarm upon very mistaken grounds. It has been suggested that an assignment of the public securities of one State to the citizens of another, would enable them to prosecute that State in the federal courts for the amount of those securities; a suggestion which the following considerations prove to be without foundation.
>
> It is inherent in the nature of sovereignty not to be amenable to the suit of an individual *without its consent*.

THE FEDERALIST No. 81, *supra*, at 422.

supra, at 69 (". . . the decision in *Chisholm* was contrary to the well-understood meaning of the Constitution. . . . That decision created 'such a shock of surprise that the Eleventh Amendment was at once proposed and adopted,'" *quoting* Principality of Monaco v. Mississippi, 292 U.S. 313, 325 (1934)).

However, the sovereign immunity cases represent but one subset of decisions serving the larger principle that the federal government may not use its Article I power to coerce the states. *Alden, supra*, at 749 ("A power to press a State's own courts into federal service to coerce the other branches of the State . . . is the power first to turn the State against itself and ultimately to commandeer the entire political machinery of the State. . . ."). Similarly protective of State sovereignty are cases striking down other efforts at federal coercion. These include holdings that protect the integrity of state legislative decision making, New York v. United States, 505 U.S. 144 (1992), and those that preserve the integrity of state executive functions. Printz v. United States, 521 U.S. 898 (1997). One teaching of these decisions is that a federal statute attempting impermissibly to coerce state governments is unenforceable because it is not a "proper" law as required by the Necessary and Proper Clause. *Id.* at 924.

The principle of preserving state "independence" from federal "coercion" embodied in the foregoing cases also applies to federal conditions imposed in grants-in-aid to the states. South Dakota v. Dole, 483 U.S. 203 (1987). To be sure, Congress may require that federal funds be applied consistently with the intent of the program. *Id.* However, overly-severe penalties for disobeying a condition render that condition "coercive" and void. *Id.* at 211 (citing Steward Machine Co. v. Davis, 301 U.S. 548, 590 (1937)).

The application of the non-coercion principle in grant-in-aid cases is entirely correct, because *that principle has particular force in fiscal affairs*. It fulfills the promise of the Constitution's advocates that congressional fiscal powers could not be used to impair state financial viability. Part III, *supra*. As Justice Kennedy wrote for the Court in *Alden*:

> It is indisputable that, at the time of the founding, many of the States could have been forced into insolvency but for their immunity from private suits for money damages. Even today, an unlimited congressional power to authorize suits in state court to levy upon the treasuries of the States for compensatory damages, attorney's fees, and even punitive damages could create staggering burdens, giving Congress a power and a leverage over the States that is not contemplated by our constitutional design. The potential national power would pose a severe and notorious danger to the States and their resources.

527 U.S. at 750.

Key to modern Supreme Court jurisprudence in this area, therefore, is the need to fulfill the Federalist commitment to protect the states from the fiscal "nightmare scenario" posited by Anti-Federalists such as "Brutus."

V. Several aspects of the Medicaid mandates render them uniquely coercive compared to other funded federal mandates.

A. The Founding-Era record reveals a specific understanding that especially in the area of social services, the states could make free decisions, uncoerced by the federal government.

The Founding-Era record reveals an express decision to leave primary jurisdiction over social services, including health care for the poor, to state, rather than federal jurisdiction. *See* Robert G. Natelson, *The Enumerated Powers of States*, 3 NEV. L.J. 469, 486 (2003). In addition to general representations to the ratifying public by Federalist spokesmen that "internal police" was to be the exclusive province of the states, *see generally id.*, Federalists addressed a number of representations *specifically* to social services. For example, Tench Coxe (who, as noted *supra*, was a particularly prominent Federalist spokesperson) emphasized the exclusive state power to "establish *poor houses, hospitals*, and houses of employment," Coxe, "A Freeman," Letter II, *reprinted in* FRIENDS OF THE CONSTITUTION, *supra*, at 96 (emphasis added).

Other Federalists said similar things. The influential pamphlet promoting the Constitution written by Maryland Judge Alexander Contee Hanson, Sr., described "protection of the weak" as an exclusive state power. Natelson, *The Enumerated Powers of States*, *supra*, at 486, n.109. In their efforts to secure ratification in Massachusetts, both the *Massachusetts Gazette* and Massachusetts Supreme Judicial Court Justice Nathaniel Peasley Sargeant represented that under the Constitution care for the poor was exclusively a state, not a federal concern. *Id.* at n.111.

Chief Justice John Marshall, not known as an opponent of legitimate federal authority, held a similar view. Marshall, who had been a prominent spokesman for the Constitution at the Virginia ratifying convention, asserted emphatically that "health laws of every description" are exclusively within the state, and outside the federal, sphere. Gibbons v. Odgen, 22 U.S. 1, 203 (1824). In the same case in which he refused to define "commerce" narrowly, Marshall repudiated the notion that "commerce . . . among the several states" could be construed to comprise health laws. Although like "inspection laws" they might "have a remote and considerable influence on commerce," they "form a portion of that immense mass of legislation, which embraces every thing within the territory of a State, not surrendered to the general government: all which can be most advantageously exercised by the States themselves. Inspection laws, quarantine laws, health laws of every description . . . are component parts of this mass." *Id.*

The Founders' emphasis on reserved state authority over social services distinguishes the instant case from precedents such as *South Dakota v. Dole*, *supra*, and *Rumsfeld v. Forum for Academic and Institutional Rights, Inc.*, 547 U.S. 47 (2006). The mandate upheld in Dole arose from conduct (automobile driving) in interstate commerce (*cf.* U.S. Const., art. I, §8, cl. 3 [setting forth the power of Congress to regulate interstate commerce]), particularly that occurring on interstate highways (*cf. id.* at cl. 7 [setting forth the power of Congress to "establish . . . post Roads"]), and the mandate was attached to an interstate highway funding program. Likewise, the mandate upheld in *Rumsfeld*, although imposed on state universities (as well as other universities), was upheld as part of Congress's enumerated authority to "raise and support Armies." U.S. Const., art. I, §8, cl. 12.

Although under modern Supreme Court jurisprudence the federal government certainly may assist the states with grants-in-aid, United States v. Butler, 297 U.S. 1, 65 (1936) (dictum); Helvering v. Davis, 301 U.S. 619, 640 (1937),[7] the representations made

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[7] To be sure, the Founding-Era record tends to show that New Deal jurisprudence was inaccurate in conceding to Congress a "general welfare" spending power. The *Butler* dictum appears to have been an anachronistic rendering of the constitutional text, Robert G. Natelson, *The General Welfare Clause and the Public Trust: An Essay in Original Understanding*, 52 U. KAN. L. REV. 1 (2003), and the single Founding-Era source for its conclusion, Alexander Hamilton's *Report on Manufactures* (*Butler, supra*, 297 U.S. at 67), was not published until *after* all states had ratified the Constitution.

(Continued on following page)

to the public to secure the Constitution's ratification strongly suggest that the non-coercion principle should be applied more rigorously in areas traditionally reserved for the states than in areas the Constitution specifically assigns to Congress, such as those at issue in prior funded-mandate cases.

Moreover, Hamilton was an advocate of an unlimited federal government, and his assertion of a "general welfare" spending power contradicted his representations of constitutional meaning prior to ratification. *Contrast* Alexander Hamilton, THE FEDERALIST No. 17, *supra*, at 81 (declaring that "The . . . supervision of agriculture and of other concerns of a similar nature . . . can never be desirable cares of a general jurisdiction") with Alexander Hamilton, *Report on Manufactures* in 4 WORKS OF ALEXANDER HAMILTON 250 (Henry Cabot Lodge ed., 1904) (Dec. 5, 1791) ("whatever concerns the general interests of learning, of agriculture, of manufactures, and of commerce, are within the sphere of the national councils, as far as regards an application of money."). The *Report on Manufactures* also contradicted preratification representations mentioned in the text of this brief.

James Monroe's *Special Message to the House of Representatives Containing the Views of the President of the United States on the Subject of Internal Improvements*, available at American Presidency Project (U. Cal. Santa Barbara), http://www.presidency.ucsb.edu/ws/?pid=66323, also cited in *Butler*, was not issued until 1822, several decades after the Founding, and by an author who had opposed the Constitution.

However, the question in the present case is not whether the Constitution authorizes "general welfare" spending as an abstract proposition, but whether Congress can use that power to *coerce* the states in the exercise of their own sovereign powers. As pointed out in *Dole, supra*, 483 U.S. 203, 207-08, the two issues are separate.

B. The ACA's Medicaid mandates do not comply with the standards previously outlined by this Court.

The cost for non-compliance with the ACA's Medicaid mandates far exceeds that upheld in *Dole*, *supra*, and probably exceeds the cost of the law invalidated in Alden, *supra*. Unlike in *Dole*, where a state could lose only five percent of program funding, the ACA authorizes the Department of Health and Human Services to strip a recalcitrant state of all of Medicaid revenue. Because of the size of the Medicaid program, this would result in state budgetary havoc of the highest order. *See* Opening/Response Brief of Appellee/Cross-Appellant States, at 6-8, *in* State of Florida et al. v. U.S. Dep't of Health and Human Services, 648 F.3d 1235 (11th Cir.), *cert. granted*, ___ U.S. ___, 2011 WL 5515165 (2011). Moreover, as noted earlier, two of the reasons the Court invalidated the federal statute in *Alden* are that the claimed congressional power "could create staggering [fiscal] burdens, giving Congress a power and a leverage over the States that is not contemplated by our constitutional design" and that the "potential national power would pose a severe and notorious danger to the States and their resources." 527 U.S. at 750. This certainly describes the penalties inflicted by the ACA.

Consider the plight of any state adopting a policy different from that mandated by the ACA. Loss of all Medicaid funding would not end Medicaid-related tax liability imposed on that state's taxpayers. Those taxpayers still would have to pay for Medicaid, but all of their money would go to other states. Indeed, one might well question whether any scheme that taxed the citizens of some states to operate such a large program exclusively for the benefit of other states would still serve the "general welfare," as opposed to regional or partial welfare. Additionally, because in today's hyper-inflating health care system, political reality requires *some* provision for health care for the poor, a state evicted from Medicaid would have to create and fund its own program. *This would result in that state's citizens being taxed twice*: once to support Medicaid exclusively for other states, and again to support their own program. This result would be reminiscent of the financial nightmare scenario posited by Anti-Federalists arguing against the Constitution and rejected by the Constitution's supporters, Part III *supra*, and guarded against by this Court. Part IV *supra*.

Thus, for practical purposes state Medicaid participation is essentially mandatory under current circumstances, and the "option" of withdrawal quite illusory. This, in turn, renders the ACA's conditions coercive.[8]

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[8] Congress could solve this dilemma by block-granting Medicaid funds, but has not done so.

C. Under the ACA, state budgetary decisions are placed at the boundless discretion of federal bureaucrats.

The Court of Appeals for the Eleventh Circuit observed that the ACA authorizes the Department of Health and Human Services to impose a penalty below 100 percent of funding. Florida v. Dept. of Health & Human Services, 648 F.3d 1235, 1268 (11th Cir. 2011), *cert. granted*, ___ U.S. ___, 2011 WL 5515165 (2011). Although that court considered this provision a mitigating factor, in fact it is an *aggravating* one.

The default rule in the ACA is the loss of all funding. HHS is permitted to withdraw a lesser amount at its discretion, but the ACA contains no real standards for exercise of this HHS discretion. 42 U.S.C. §1396c. Thus, the ACA delegates to unelected bureaucrats enormous uncontrolled power over state budgetary policy. Should a state refuse to comply with one or more mandates, that state would be punished with paralyzing uncertainty at best. A grant of such uncontrolled bureaucratic power over state governments surely is inconsistent with the sovereign dignity reserved to the states as recognized by the Constitution's text, the understanding at the Founding, and the decisions of this Court.

D. The Medicaid mandates are an effort by Congress unilaterally to rewrite the Constitution.

Central to the American system of federalism is the freedom of the States, as sovereign within their sphere, to make their own policy judgments. This is particularly true of such areas as social services, a subject expressly recognized at the Founding as a matter for exclusive *state* jurisdiction. The ACA's coercive Medicaid mandates, enforced by penalties designed to cripple any state that demurs, comprise a clear example of a congressional effort to rewrite the Constitution's system of federalism into one in which the states are mere puppets of Congress. As such, those mandates are unconstitutional and void.

◆

CONCLUSION

The decision of the Court of Appeals on the Medicaid mandates should be reversed.

Respectfully submitted,

DAVID B. KOPEL
Counsel of Record
INDEPENDENCE INSTITUTE
727 East 16th Avenue
Denver, Colo. 80203
(303) 279-6536
Counsel for Amicus Curiae

AMICUS
CURIAE
BRIEF

No. 11-400

IN THE

Supreme Court of the United States

STATE OF FLORIDA, ET AL.,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, ET AL.,

Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* INDIANA STATE LEGISLATORS, THE JAMES MADISON INSTITUTE, AND CHRISTOPHER CONOVER IN SUPPORT OF PETITIONERS (MEDICAID ISSUE)

Of Counsel
THOMAS M. CHRISTINA
OGLETREE, DEAKINS, NASH, SMOAK & STEWART, P.C.
300 North Main Street
Suite 500
Greenville, SC 29601
(864) 271-1300
tom.christina@ogletreedeakins.com

ASHEESH AGARWAL
Counsel of Record
OGLETREE, DEAKINS, NASH, SMOAK & STEWART, P.C.
111 Monument Circle
Suite 4600
Indianapolis, IN 46204
(317) 916-1300
asheesh.agarwal@ogletreedeakins.com
Counsel for Amici Curiae

January 17, 2012

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INTEREST OF THE AMICI CURIAE[1]

Amici Curiae Indiana Legislators are state senators and representatives elected by the citizens of Indiana. The *amici* Legislators have a substantial interest in the validity of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Title I of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (collectively, "ACA" or "the Act"), particularly as related to the preservation of federalism and the integrity of state budgets.

The *amici* Members of the Indiana House of Representatives are as follows: Speaker Brian Bosma, and Representatives Ronald Bacon, James Baird, Robert Behning, Bruce Borders, Timothy Brown, Woody Burton, Roberty Cherry, Edward Clere, Suzanne Crouch, Wes Culver, Bill Davis, William Davis, Steve Davisson, Thomas Dermody, Sean Eberhart, Jeffrey Espich, Ralph Foley, William Friend, David Frizzell, Randy Frye, Douglas Gutwein, Robert Heaton, Kathy Heuer, Michael Karickhoff, Cindy Kirchhofer, Earl Allan Koch, Rebecca Kubacki, Donald Lehe, Matthew Lehman, Daniel Leonard, Kevin Mahan, Richard McClain, Jud McMillin, Wendy McNamara, Robert Morris, Timothy Neese, Cindy Noe, Rhonda Rhoads, Kathy Richardson, Milo Smith, Mike Speedy, Gregory

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[1] The parties have consented to the filing of this brief in letters of consent on file with the Clerk. No counsel for any party had any role in authoring this brief, and no one other than the *amici curiae* provided any monetary contribution to its preparation or submission.

Steuerwald, Jeffrey Thompson, Jerry Torr, Randy Truitt, P. Eric Turner, Matthew Ubelhor, Heath VanNatter, Timothy Wesco, David Wolkins, and David Yarde,

The *amici* Members of the Indiana Senate are as follows: President Pro Tempore David Long, and Senators Mike Delph, Brandt Hershman, Travis Holdman, Luke Kenley, Sue Landske, Connie Lawson, James Merritt Jr., Patricia Miller, and Brent Steele.

Amici Curiae The James Madison Institute was established in 1987 as a nonpartisan public policy center dedicated to advancing the principles of limited government, individual liberty, personal responsibility, and federalism within the original intent of the authors of the United States Constitution. The Institute's scholars have published numerous studies concerning the state of Florida's tax and budget policies, including several specifically dealing with the enormous impact of Medicaid upon the state budget. The current case centrally concerns the Institute because it represents an egregious violation of the concept of federalism as delineated in the Tenth Amendment.

Amici Curiae Christopher Conover, Ph.D., is a Research Scholar in the Center for Health Policy & Inequalities Research at Duke University and Mercatus Affiliated Senior Scholar. Dr. Conover has researched Medicaid and the medically indigent for many years.

SUMMARY OF ARGUMENT

Federalism is one of the cornerstones of our constitutional system. By reserving broad powers to the States and to the people, federalism protects liberty, enhances accountability, and fosters innovation. The Act, however, undermines the essence of federalism by denying States a meaningful choice on whether to expand their state Medicaid programs. States depend heavily on the hundreds of billions of dollars dispersed by the federal government through Medicaid. Because the federal government funds at least half of each State's Medicaid costs, no State could operate a comparable program without federal dollars, and no State could realistically decline to offer basic medical care to its neediest citizens. Nevertheless, the Act requires States to spend tens of billions of additional dollars to expand Medicaid coverage, and threatens States with the loss of all Medicaid funding unless they comply. Accordingly, the Act leaves States with no realistic choice but to continue to participate in Medicaid, in violation of the Tenth Amendment and the principles of federalism articulated in *South Dakota v. Dole*.

Moreover, because of Medicaid's size and the Act's all-or-nothing penalty provisions, the Act is uniquely suited for scrutiny under the coercion doctrine. Medicaid represents far and away the largest source of federal outlays to the States, and the largest component of spending by the States. The Act, in turn, requires States to spend tens of billions of additional dollars to expand coverage, on penalty of losing every last dollar of federal Medicaid support.

These and other provisions suggest that Congress designed the Act to preclude the States from exercising a meaningful choice. For these reasons, if the coercion doctrine is *ever* to have any role in protecting the principles of constitutional federalism, the Act must be deemed invalid.

ARGUMENT

I. THE ACA LEAVES STATES WITH NO REALISTIC ABILITY TO OPT OUT OF MEDICAID.

A. States Are Dependent on Federal Medicaid Dollars.

Established in 1965, Medicaid is a cooperative federal-state partnership designed to provide medical assistance for specific categories of needy individuals. *Harris v. McRae*, 448 U.S. 297, 301 (1980); *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). As originally designed, Medicaid was to be partially funded by the States, with federal funding covering at least half of each State's costs. *See* 42 U.S.C. § 1396d(b).

By any measure, Medicaid represents the largest category of federal outlays to the States. In absolute dollars, the federal government is projected to spend nearly $4.4 trillion on Medicaid over the next ten years, which represents approximately 9% of all federal spending. *See* Office of Mgmt. & Budget, Exec. Office of the President, *Budget of the United States Government, Fiscal Year 2012*, at 174 (2011). In fiscal year 2010, the federal government distributed more than $233 billion for Medicaid to the States. Nat'l Ass'n of State Budget Officers, *2010 State Expenditure Report: Examining Fiscal 2009-2011 State Spending*, at 47 (2011) (hereinafter NASBO Report). Today, nearly one in five Americans receives some assistance through Medicaid. *See id.* at 44 (noting that Medicaid "provides comprehensive and long-term medical care for more than 60 million low-income individuals").

Medicaid dwarfs all other federal outlays to the States. In 2010, the federal government directed more than $552 billion in federal funds to the States. NASBO Report at 7. Fully 42.3 percent of this spending went for Medicaid. *Id.* at 9. By way of comparison, the next largest categories of state spending from federal funds are elementary and secondary education, which are mostly funded at the state and local levels, at 12.7 percent, and transportation, at 7.2 percent. *Id.* In other words, the federal government gives the States more than three times as much money for Medicaid as for the next largest category of programs, and twice as much for Medicaid as the next two largest program categories combined. Medicaid is the 900-billion-pound gorilla of federal intergovernmental transfers.

These federal dollars are the life blood of the States' Medicaid programs. Federal funds cover anywhere from 50 to 83 percent of each State's Medicaid costs. 42 U.S.C. § 1396d(b). In 2010, most States received more than $1 billion in federal Medicaid funding, and a quarter of States received more than $5 billion. *See* NASBO Report at 47. Without federal funding, state Medicaid programs could not operate as currently constituted and funded.

Even with these federal dollars, States already spend a larger percentage of their budgets on Medicaid than on any other item. In fiscal year 2011, Medicaid accounted for about 22.3 percent of total state spending. *Id.* at 5. In comparison, States spent approximately 20.5 percent of their budgets on elementary and secondary education, 10.2 percent on higher education, and 7.7 percent on transportation. *Id.* Because Medicaid already consumes the single largest percentage of total state spending, any significant mandatory increase would drastically upset state budgetary priorities.

B. The ACA Compels States to Spend Billions of Additional Dollars on Medicaid.

Notwithstanding Medicaid's current costs, the ACA requires that States spend tens of billions of additional dollars over the next decade and beyond. Pursuant to the ACA, States must enroll millions of additional people in Medicaid and bear a range of administrative costs. Although the federal government covers a high percentage of the costs of new enrollees, the sheer size of Medicaid still leaves the States holding a very expensive bag.

According to numerous studies, the ACA will cost States $20-40 billion over the short term and up to $120 billion over the next decade, despite the federal government's increased contributions. The nonpartisan Congressional Budget Office (CBO) has estimated new state spending on Medicaid at $20 billion between 2010 and 2019. True Cost of PPACA: Effects on the Budget and Jobs Hearing Before the H. Subcomm. on Health of the H. Comm. on Energy

& Commerce, 112th Cong. (March 30, 2011) (written testimony of CBO Director Douglas W. Elmendorf: CBO's Analysis of the Major Health Care Legislation Enacted in March 2010 at 24) (hereinafter CBO Report). An independent report from the Kaiser Commission estimates new state spending at $43.2 billion through 2019. Randall R. Bovbjerg et al., Kaiser Commission on Medicaid and the Uninsured, State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts 4 n.27 (Feb. 2011) (hereinafter Kaiser Report).

After 2019, state spending will increase at a faster rate. The CBO estimates new state spending at $60 billion through 2021. CBO Report, *supra*, at 24. Another congressional report comprehensively examined state government estimates, which States use to manage their own budgets. *See* S. Fin. Comm. & H. Energy & Commerce Comm., 112th Cong., *Medicaid Expansion in the New Health Law: Costs To The States* (hereinafter Joint Committee Report). This report "conservatively estimates that PPACA will cost state taxpayers *at least* $118.04 billion through 2023." *Id.* at 2 (emphasis in original).[2]

These additional costs stem largely from new enrollees in Medicaid. Prior to enactment of the ACA, Medicaid allowed States substantial discretion in determining eligibility based on federal poverty levels. Beginning in 2014, however, the ACA requires state Medicaid programs to cover non-pregnant, non-elderly individuals with incomes up to 133 percent of the federal poverty level. NASBO Report, *supra*, at 44. In most places, States will have to provide Medicaid to adults without dependent children for the first time ever, and also will have to increase the income eligibility level for parents. As a result, States will have to enroll 15 to 20 million additional people in their Medicaid systems. Mitch Daniels, *An ObamaCare Appeal From the States*, Wall St. J., Feb. 7, 2011 (hereinafter Daniels). Through 2016, the federal government will fully fund this requirement, but by 2020 and thereafter, it will cover only 90 percent of these costs, thereby leading to even higher state costs over the long term. NASBO Report, *supra*, at 44.

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[2] The cost estimates vary because they encompass different time periods and rely on different assumptions. For example, some studies ignore the costs of administration. Other studies apply different methodologies to estimate the number of new enrollees or potential to reduce the costs of uncompensated care. *See generally* Kaiser Report, *supra*.

The ACA also leaves the States to bear significant administrative costs. According to one analysis, the ACA's administrative costs will approach $12 billion total between fiscal years 2014 and 2020. Edmund F. Haislmaier & Brian C. Blasé, The Heritage Foundation, *Obamacare: Impact on States*, in Backgrounder No. 2433 (July 1, 2010) (hereinafter Haislmaier & Blasé). Among other administrative tasks, States must create new systems to simplify and coordinate eligibility and enrollment for Medicaid. *See* Kaiser Report, *supra*, at vi (noting that administrative costs typically range from five to eight percent of all new spending). States also must use their "current welfare apparatuses to do the numbingly complex work of figuring out who is eligible for its subsidies, how much each person or family is eligible for, redetermining this eligibility regularly, and more." Daniels, *supra*.

Finally, States will incur a variety of other costs. For example, the ACA changes the drug rebate allocation between the federal government and the States. Due to this change, Florida expects to lose $40 million in rebates in fiscal year 2010-2011. Joint App. on Medicaid at 76. Nebraska estimates a total loss of between $68.1 and $74.4 million for fiscal years 2011 through 2020, *id.* at 149, and Texas expects to lose $70.4 million in rebate revenue from 2010 to 2013, *id.* at 190. States also may have to pay higher physician fees after 2014. *See* Kaiser Report, *supra*, at vi (discussing cost categories).

These new costs will dramatically reshape state budgets. According to one study, the increased expenditures, particularly on long-term care, will cause the percentage of state operating budgets devoted to Medicaid nearly to double by 2030. Deloitte Center for Health Solutions, *Medicaid Long-term Care: The Ticking Time Bomb* at 5 (2010). In New York, Medicaid expenses could consume nearly 40 percent of the state budget by 2030. *Id.*

Similarly, in a relatively poorer state such as Mississippi, the ACA will cause Medicaid to swallow the State's budget. According to a study commissioned by the State, the ACA's average yearly impact on the budget will range from $86 million to $166 million, depending on the actual number of new enrollees. Lanhee J. Chen, The Heritage Foundation, *How Obamacare Burdens Already Strained State Budgets* 4-5, Backgrounder No. 2489 (Nov. 10, 2010). Using the study's "moderate participation" scenario, the ACA will add about $126 million in average yearly spending to Mississippi's budget between 2011 and 2020. *Id.* at 5. This amount of spending far exceeds the amount the State will spend on its public safety, military, and veterans affairs agencies combined. *Id.* Moreover, the average yearly cost of the Act's Medicaid expansion far exceeds what the State spends on vocational and technical education, and represents more than four times the amount spent on student financial aid at the State's institutions of higher learning. *Id.*

The new requirements could force some States to spend *billions* of extra dollars a year. California, for example, will spend at least another $19.4 billion on Medicaid, leading former Governor Schwarzenegger to call the ACA "a disaster for California." Joint Committee Report, *supra*, at 2. Texas estimates that, starting in 2014, it will have to spend an extra $27 billion over ten years—"more than the program's entire annual budget today." *Id.* The new requirements will particularly affect Texas, Nevada, and Oregon, three states whose Medicaid populations are expected to grow by fifty percent or more because of the ACA. Chen, *supra*, at 3. Numerous other States paint fiscal pictures that are equally bleak. *See, e.g.*, Joint App. on Medicaid 116 ¶ 5 (Arizona anticipates additional spending of between $7.5 and $11.6 billion over ten years); 135 ¶ 4 (Louisiana anticipates losing $7 billion in federal matching funds over thirteen years).[3]

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[3] As economist Dr. Chris Conover explains, "ACA is essentially forcing states to swallow an increase in their Medicaid burden that will be about one fifth larger than it

For smaller States, the ACA could puncture their already fragile budgets. Idaho determined that the law would grow its Medicaid program by nearly fifty percent. Joint Committee Report, *supra*, at 2. *See also* Kaiser Report, *supra* (discussing various cost estimates). In Indiana, independent actuaries have pegged the price to state taxpayers at $2.6 billion to $3 billion over the next ten years. Daniels, *supra*. According to Indiana Governor Mitch Daniels, "This is a huge burden for our state, and yet another incremental expenditure the law's authors declined to account for truthfully." *Id.*

C. States Have No Meaningful Choice Except to Comply with the ACA.

To incent the States to remain in Medicaid, the ACA takes an unprecedented step: it conditions a State's continued receipt of *all* federal Medicaid funds on its acquiescence to the massive changes brought about by the ACA. Rather than simply withhold *additional* funding should States decline to expand coverage, Congress has threatened to

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would have been under the status quo (i.e., 8.2 percentage points above the 44.7 percentage point increase states would have expected to accept under the current rules of the road). Here the consequences of rejecting Medicaid become more stark: this burden would increase ***247 percent*** for the average state electing not to accept the conditions laid out in ACA. Perhaps the analogy is a bad one, but in my non-lawyer's view of the world, this is roughly equivalent to the neighborhood kid asking for a $20 'donation' by threatening to inflict $250 damage on your property if you decline. Is such a donation voluntary or coerced?" Conover, ***Medicaid Coercion--In Your Heart You Know the States are Right: Healthcare Fact of the Week*** (2012) (emphasis in original) (hereinafter Conover).

withhold *all* Medicaid funding if States reject the Act's terms. *See* Julie Stone et al., Cong. Research Serv., *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA*, at 2 (Apr. 28, 2010) (stating that "the law requires states to expand Medicaid"). In other words, the Act gives a State an all-or-nothing choice: accept the Act's terms, expand coverage, and spend billions of extra dollars, or forfeit the largest source of federal outlays to the States, approximately one to five billion dollars per State, per year, and shoulder the Herculean task of providing health coverage for the indigent solely from state revenues. Thus, the Act "incents" States to expand Medicare coverage with a stick the size of a Sequoia.

Indeed, the Act assumes that no State would or could opt out of Medicaid. The ACA imposes an individual mandate that requires all individuals to obtain health insurance, *see* ACA § 1501(b), and provides subsidies for individuals with incomes from 100-400% of the federal poverty line, *see* ACA § 1401(a). Perhaps counter-intuitively, however, the ACA does not provide subsidies to individuals with income under 100% of the poverty line; instead, it conclusively presumes they will have a state Medicaid program to join. In analyzing the Act's budgetary impact, a Nevada agency explained how these anomalous subsidy provisions expose Congress's true intent:

> It is clear from both the Senate and House health reform bills that Congress did envision the possibility of states reducing Medicaid coverage and spending. Both bills try to

> forestall such state action by mandating that states maintain eligibility in the program, and both bills try to sweeten the deal by adding additional federal Medicaid funding for some aspects of the proposed expansion. However, *Congress did not appear to envision a scenario where a state or states chose to act in their financial best interest by opting out of Medicaid*. This is evidenced by the lack of credits and subsidies in both bills for citizens who would otherwise qualify for Medicaid.

Nevada Dep't of Health and Human Servs. & the Div. of Health Care Financing and Policy, Medicaid Opt Out White Paper at 18 (Jan. 22, 2010) (emphasis added) (hereinafter Nevada Report).

Accordingly, a State has a "choice" of whether to comply with the ACA in only the strictest, most formalistic sense of the word. In theory, a State could opt out of Medicaid, lose billions of dollars of federal support, and watch its citizens' tax dollars flow to the Medicaid programs of other States. The State then could, again in theory, either raise taxes on its citizens by one to five billion dollars annually to compensate for the loss of federal funds, cut other spending to the marrow, or leave roughly one-fifth of its poorest citizens and children without basic medical care (or some combination thereof). As this description suggests, any purported "choice" amounts to nothing more than a cruel fiction.

States cannot realistically raise taxes enough to compensate for the loss of federal Medicaid funds. To maintain their programs at pre-ACA levels, States would need to raise taxes by an average of 39.7 percent in 2013. Edmund F. Haislmaier, The Heritage Foundation, *Quantifying Costs to States of Noncompliance with the PPACA's Medicaid Expansion* at 4 (Jan. 12, 2012). While a 40 percent tax hike may sound unpalatable (and unrealistic), many States would have to raise taxes even higher. *Id.* at 3. To cover a loss of federal Medicaid funding, Alabama would need to increase its projected $7.5 billion in general-fund revenues by another $4 billion, or 53 percent. *Id.* Arizona and Louisiana would have to increase general-fund revenues by more than 60 percent, while Mississippi and Missouri would have raise taxes by more than 70 percent. *Id.* Due to the economic and budgetary situation in Michigan, that State would have to raise revenues by *more than 88%* to compensate for a loss of federal Medicaid funds. *Id.*[4]

In addition to the sheer magnitude of the higher state tax burden, the ongoing federal tax burden further constrains any State that might consider raising state taxes to compensate for the loss of federal funds. The ACA does not provide a State with a rebate, or partial rebate, of its citizens' tax dollars if the State chooses to opt out of Medicaid.

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[4] As Dr. Conover explains, a State would almost quadruple the state tax burden on its citizens by opting out of Medicaid and maintaining a comparable program on its own: "the average state collected $477 per capita to pay for the state share of Medicaid. Under the status quo, that will grow to nearly $930 by 2019, a 95 percent increase; under the ACA, it will more than double. But what happens to the average state electing to reject ACA? State Medicaid revenues per resident will balloon by 371 percent." Conover, *supra*.

See, e.g., Lynn A. Baker, *The Spending Power and the Federalist Revival*, 4 Chap. L. Rev. 195, 213-14 (2001) ("[S]hould a state decline proffered federal funds because it finds a condition intolerable, it receives no rebate of any tax dollars that its residents have paid into the federal fisc. In these cases, the state (through its residents) contributes a proportional share of federal revenue only to receive less than a proportional share of federal spending."). Therefore, if a State opted out of Medicaid, its citizens would continue to have to pay the same amount of taxes to support the federal Medicaid program, in addition to paying new, higher state taxes to support the State's independent medical program. No State would or could "choose" to forfeit one to five billion dollars annually of its citizens' tax dollars to Washington, D.C., and to other States, and then raise taxes on its citizens by an equivalent amount. Perhaps for some programs, such as a few million dollars in highway funds, the States and their taxpayers might willingly pay higher state taxes, as well as federal taxes, to avoid unpalatable federal mandates. As the largest single source of federal outlays to the States, Medicaid is not one of those programs. Medicaid's magnitude matters.

Furthermore, given the size of Medicaid's disbursements, States cannot realistically cut other spending enough to compensate for the loss of federal dollars. In many States, of course, budgets are already very lean due to ongoing economic maladies. If a State chose to opt out of Medicaid, it would have to double, triple, or even quadruple its own Medicaid spending to provide a similar level of pre-ACA medical care. Connecticut, a wealthy state that receives the minimum federal Medicaid contribution of 50 percent, would still have to double state Medicaid spending to replace the half currently paid by the federal government. *See* Haislmeier, *supra*, at 4. In Mississippi, which receives a federal Medicaid contribution of 75 percent, the state government would have to *quadruple* state Medicaid spending to replace the three-quarters share currently paid by the federal government. *Id.* Such increases would necessarily crowd out other critical spending in the next largest categories of state spending, including education, transportation, and public safety. *See id.*

Finally, States cannot plausibly terminate medical support for their neediest citizens. As this Court has recognized, "a complete withdrawal of the federal prop in the system . . . could seriously cripple a state's attempts to provide other necessary medical services" to its residents. *Harris v. McRae*, 448 U.S. 297, 309 n.12 (1980) (quoting *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 132 (1st Cir. 1979)). According to the National Association of State Budget Officers, while state general fund spending is expected to grow slowly over the next few years, spending on Medicaid will continue to show above average growth as a result of increased demand driven by the economic downturn and other factors. NASBO Report, *supra*, at 3.

If, hypothetically, a State did opt out of Medicaid, the impact on its residents would border on the unthinkable, if not the inhumane. In Nevada, for example, the "Nevada Safety Net for Health would provide continued medical assistance to the most vulnerable," but "as many as 200,000" Medicaid-eligible Nevadans "will not be able to obtain or afford coverage through the proposed Health Insurance Exchanges, and will merely add to the numbers of uninsured" and "increase the cost burden to providers, state and local governments to serve the poor." What is more, "another 40,000 Nevada seniors will not receive the supplemental benefits to Medicare they currently receive from Medicaid." Nevada Report at 23. These uninsured, ineligible individuals "would lose access to prenatal care, inpatient and outpatient hospital services, professional medical care, pharmaceuticals, infant and child preventive care, behavioral health care, dialysis, and Medicaid hospice care." *Id.* at 20. No State would voluntarily "choose" to inflict such pain on its citizens.

Furthermore, even if a State was inclined to opt out of Medicaid, the State would still have to comply with other costly aspects of federal law, without the benefit of federal Medicaid dollars. For example, federal law requires certain levels of coverage for some quickly growing cost items, such as care at nursing facilities. *See* Ctrs. for Medicare & Medicaid Servs., Your Guide to Choosing a Nursing Home 18 (noting that "[f]ederal law requires all Medicare and/or Medicaid-certified nursing homes provide enough staff to provide care for each resident based on their needs"). Similarly, federal law requires providers to care for patients under some circumstances even if those patients cannot pay for the medical services. *E.g.*, 42 U.S.C. § 1395dd.

For these reasons, the Act stands in a class by itself in terms of its ability to cast a State into an immediate and insoluble budget crisis. An opt-out State would lose more than incremental federal funding. It would lose all federal funding for a program necessary to provide immediate, life-or-death care to a substantial bloc of its citizens.

D. The ACA Unconstitutionally Coerces States into Remaining in Medicaid.

As this Court has explained, Congress may not coerce States with terms so onerous as to eliminate their freedom to decide whether to participate in a federal program. *New York v. United States*, 505 U.S. 144, 166 (1992). "Our decisions have recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (quoting *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

These guidelines protect the integrity of state finances and the political accountability of the nation's federalist system of government. Federal coercion may threaten States' financial integrity, create "staggering burdens," and give the federal government "leverage over the States that is not contemplated by our constitutional design." *Alden v. Maine*, 527 U.S. 706, 750 (1999). "The potential national power would pose a severe and notorious danger to the States and their resources." *Id.* Moreover, "[b]y forcing state governments to absorb the financial burden of implementing a federal regulatory program, Members of Congress can take credit for 'solving' problems without having to ask their constituents to pay for the solutions with higher federal taxes." *Printz v. United States*, 521 U.S. 898, 930 (1997).

In evaluating whether Congress has coerced a State, or allowed the State to exercise a meaningful choice, this Court has adopted a functional analysis, rather than a purely formalistic analysis. In *Steward Machine*, for example, this Court rejected a coercion claim only after finding that a State could make a choice "of her unfettered will, [and not] under the strain of a persuasion equivalent to undue influence[.]" 301 U.S. at 590. "[T]he point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, of fact." *Id.*; *cf. Frost v. R.R. Comm'n of State of Cal.*, 271 U.S. 583, 593 (1926) ("no choice" exists where the alternatives are "to forego a privilege which may be vital to [one's] livelihood or submit to a requirement which may constitute an intolerable burden"); *Lee v. Weisman*, 505 U.S. 577, 595 (1992) ("Law reaches past formalism. And to say a teenage student has a real choice not to attend her high school graduation is formalistic in the extreme").[5]

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[5] In *Citizens United v. Fed. Election Comm'n*, 130 S.Ct. 876, 892-896 (2010), this Court decided to address the facial validity of a provision of federal campaign finance law. Among its reasons, the Court cited "the primary importance of speech itself to the integrity of the election process." *Id.* at 895. In this vein, the opinion noted that the regulatory scheme might not be a prior restraint on speech in the strictest sense of that term, but analyzed the scheme based on its practical consequences: "As a practical matter . . . [the] restrictions . . . function as the equivalent of prior restraint by giving the FEC power analogous to licensing laws implemented in 16th- and 17th-century England, laws and governmental practices of the sort that the First Amendment was drawn to prohibit." *Id.* at 895-96. Like freedom of political speech, federalism is a cornerstone of the Constitution. *See, e.g., U.S. Term Limits, Inc. v. Thornton*, 514

The line between influence and coercion depends, in part, on the magnitude of the harm. In *Dole*, for example, the Court considered the State's argument "more rhetoric than fact" because the stakes were so low: the price of refusing federal prescriptions was only five percent of certain highway-related grant funds. 483 U.S. at 211.

On the other hand, the coercion doctrine should apply where Congress adopts an all-or-nothing strategy with enormous federal funding consequences. In *College Savings Bank v. Florida Prepaid Postsecondary Education Expense Board*, 527 U.S. 666, 687 (1999), all nine Justices acknowledged the coercion doctrine in a case that closely divided on the question of whether a federal act unlawfully could "coerc[e]" a State to waive its sovereign immunity as a condition of pursuing lawful activity. The majority approvingly quoted *Dole*'s "financial inducement" coercion standard. *Id.* In a dissenting opinion, Justice Breyer, joined by three other Justices, discussed the coercive effect of compelling a State to forgo federal funds. *Id.* at 693-705. The dissent suggested that it may be "compelling or oppressive" for Congress to condition substantial funding sent to States annually, such as for highways ($20 billion in 1998), or especially, for education ($21 billion in 1998). *Id.* at 697. *See also United States v. Butler*, 297 U.S. 1, 71 (1936)

U.S. 779, 838 (1995) (Kennedy, J., concurring) ("It was the genius of [federalism] that our citizens would have two political capacities, one state and one federal, each protected from incursion by the other."). Federalism's importance provides an additional reason for evaluating the coerciveness of the Act's Medicaid provisions based on its practical effects.

(holding that coercion occurs where a refusal to accept benefits may result in "financial ruin").

Here, the Act pressures the States past "the point at which 'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Mach.*, 301 U.S. at 590). Because Medicaid represents far-and-away the largest source of federal disbursements to the States, and the largest single category of spending by the States, the Act dwarfs the "mild encouragement" upheld in *Dole*. *Id.* "[W]hat Congress threatens if the State refuses to agree to its [ACA] condition is not the denial of a gift or gratuity, but a sanction" in violation of State sovereignty and the Constitution's federalism principles. *See Florida Prepaid*, 527 U.S. at 687.

An analogy to the law of contracts further demonstrates the coercive nature of the ACA. Federal spending legislation "is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). When Congress conditions acceptance of federal funds upon adoption of a federal regulatory program, the legality of Congress's action "rests on whether the State voluntarily and knowingly accepts the terms" Congress has attached to the funds. *Id.* The federal government may not "surpris[e] participating States with post acceptance or 'retroactive' conditions." *Id.* at 25.

In contract law, courts have long recognized that a party "coerces" a promise from another party by attempting to renegotiate a contract on which the other party has reasonably relied. *See, e.g., Alaska*

Packers' Ass'n v. Domenico, 117 F. 99, 100-02 (9th Cir. 1902) (holding that sailors impermissibly coerced a promise of higher wages by refusing to fully perform a contract after the owner had lost the ability to find other sailors); *see also* Brief for James F. Blumstein as Amicus Curiae in Support of Cross-Appellants the State of Florida, et al. at 8-17, *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235 (11th Cir. 2011) (No. 11-11067) (explaining how the ACA impermissibly modifies the contract between the federal government and the States). Over the past half-century, the States have come to depend upon federal Medicaid dollars. They should not have to "choose" between accepting burdensome new conditions, or losing all of the benefits of the original contract, when they have no other realistic option.

Similarly, courts have recognized that an entity with monopoly power can coerce market participants by illegally leveraging or "tying" the sale of one product to the purchase of another product. *LePage's Inc. v. 3M*, 324 F.3d 141, 154-57 (3d Cir. 2003) (en banc) (reasoning that the threat of lost rebates could coerce buyers into purchasing tape only from the monopolist); *SmithKline Corp. v. Eli Lilly & Co.*, 575 F.2d 1056, 1065 (3d Cir. 1978) (holding that coercion occurs where the buyer was effectively "force[d]" to purchase the tied product). With the ACA, Congress, which exercises monopoly power over the federal fisc, has impermissibly threatened States with the loss of *all* federal Medicaid funds unless they agree to expand coverage by adhering to the ACA. Given the size and scope of Medicaid, States are locked into compliance with the Act's terms, regardless of the additional costs. As a matter of both contract law and constitutional law, Congress's actions impermissibly coerce the States into accepting the terms of the ACA.

II. THE ACA IS UNIQUELY SUITED FOR SCRUTINY UNDER THE COERCION DOCTRINE.

The coercion doctrine helps to protect the liberty of individual Americans. "The Constitution does not protect the sovereignty of states for the benefit of the States or state governments as abstract political entities, or even for the benefit of the public officials governing the States. To the contrary, the Constitution divides authority between federal and state governments for the protection of individuals." *New York v. United States*, 505 U.S. 144, 181 (1992). When one level engages in excesses, the other level of government serves as a channel for renewed expressions of self-government. This careful balance enhances the express protections of civil liberties within the Constitution.

If there ever was a law that cried out for scrutiny under the coercion doctrine, it is the Affordable Care Act. Although this Court has never invalidated a law pursuant to the coercion doctrine, there are multiple factors that place the ACA in a league of its own: (1) the magnitude of Medicaid, which represents by far the largest category of federal outlays to the States, and the largest category of spending by the States; (2) the size of the Act's financial impact on the States, which requires them to increase Medicaid spending by tens of billions of dollars; (3) the Act's all-or-nothing penalty provisions, which threaten States with the loss of *all* Medicaid funds, not just funds associated with the Act's new requirements; (4) the practical and political impossibility of forgoing federal Medicaid funds, which benefit citizens in a more immediate, critical manner than even education or transportation funds; (5) the existence of federal minimum care requirements that severely constrict a State's ability to dispense care without Medicaid dollars; and (6) Congress's assumption, as reflected within the Act itself, that no State could or would opt out of its provisions.

Due to the combination of these factors, the Court need not determine a precise line at which influence turns into unconstitutional coercion. Each of these factors provides a basis for distinguishing the Act from routine, run-of-the-mill spending decisions by Congress. While there is doubtless a line at which influence turns into duress, and while that line lies somewhere between the few millions at issue in *Dole* and the $120 billion at issue here, the ACA, more than any other statute in history, clearly falls on the coercion side of the line.

CONCLUSION

For these reasons, States have no meaningful choice other than to comply with the ACA. Accordingly, the ACA is invalid under the Tenth Amendment and the principles of federalism articulated in *South Dakota v. Dole*.

Respectfully submitted,

Of Counsel
THOMAS M. CHRISTINA
OGLETREE, DEAKINS, NASH,
SMOAK & STEWART, P.C.
Suite 500
300 North Main Street
Greenville, SC 29601
(864) 271-1300
tom.christina@ogletreedeakins.com

ASHEESH AGARWAL
Counsel of Record
OGLETREE, DEAKINS, NASH,
SMOAK & STEWART, P.C.
Suite 4600
111 Monument Circle
Indianapolis, IN 46204
(317) 916-1300
asheesh.agarwal@ogletreedeakins.com
Attorneys for the Amici Curiae

AMICUS
CURIAE
BRIEF

Supreme Court, U.S.
FILED
JAN 6 2012

Nos. 11-393 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, et al.,
Petitioners,

v.

KATHLEEN SEBELIUS, Secretary of Health and Human Services, et al.,
Respondents.

STATE OF FLORIDA, et al.,
Petitioners,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF JUSTICE AND FREEDOM FUND AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS (SEVERABILITY)

JAMES L. HIRSEN
Counsel of Record
505 S. VILLA REAL DRIVE
SUITE 208
ANAHEIM HILLS, CA 92807
(714) 283-8880
hirsen@earthlink.net

DEBORAH J. DEWART
620 E. SABISTON DRIVE
SWANSBORO, NC 28584
(910) 326-4554
debcpalaw@earthlink.net

Counsel for Amicus Curiae

January 6, 2012

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

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INTEREST OF *AMICUS*[1]

Justice and Freedom Fund, as *amicus curiae*, respectfully submits this brief on the issue of severability and argues that the Patient Protection and Affordable Health Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("the Act") should be stricken in its entirety because the unconstitutional mandate is so integral to the legislative scheme that it should not be severed.

Justice and Freedom Fund is a California non-profit, tax-exempt corporation formed on September 24, 1998 to preserve and defend the constitutional liberties guaranteed to American citizens, through education and other means. JFF's founder is James L. Hirsen, professor of law at Trinity Law School and Biola University in Southern California and author of New York Times bestseller, *Tales from the Left Coast*, and *Hollywood Nation*. Mr. Hirsen has taught law school courses on constitutional law. Co-counsel Deborah J. Dewart is the author of *Death of a Christian Nation*, released in 2010.

JFF has made numerous appearances as *amicus curiae* in this Court and several of the federal circuits, including the recent Fourth and Eleventh Circuit cases litigating the Act.

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[1] The parties have consented to the filing of this brief. *Amicus curiae* certifies that no counsel for a party authored this brief in whole or in part and no person or entity, other than *amicus*, its members, or its counsel, has made a monetary contribution to its preparation or submission.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Amicus curiae Justice and Freedom Fund concurs with the Eleventh Circuit decision holding that the Commerce Clause does not grant Congress authority to compel every American to purchase health insurance. The Necessary and Proper Clause cannot salvage the Act, because Congress itself created the financial "necessity" for the individual mandate—its centerpiece. The mandate is "necessary" but manifestly improper—it exceeds congressional powers under the Commerce Clause and jeopardizes the fundamental freedoms that Americans cherish.

But rather than sever the individual mandate, as the Eleventh Circuit did, this Court should strike the entire Act. Although such action may initially appear to be a greater intrusion into legislative territory, it actually preserves the separation of powers by not entangling the Court in the extensive rewriting necessary to ferret out the sections that can and cannot be sustained after the mandate is excised.

The normal presumption of severability should be abandoned in light of several key factors:

- Statutory language that unequivocally states the mandate is necessary;
- Warnings Congress received from its own legal counsel about potential constitutional flaws;
- Congress's deliberate removal of a severability clause included in an early draft of the Act.

The Florida District Court's thorough discussion of severability is the most helpful judicial analysis of the issue in the lower courts. *Florida v. United States Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1299-1305 (N.D. Fla. 2011) ("*Florida v. HHS*").

ARGUMENT

I. THIS COURT SHOULD STRIKE DOWN THE ENTIRE ACT IN ORDER TO PROTECT THE DOCTRINE OF SEPARATION OF POWERS AS MANDATED BY THE CONSTITUTION.

Severance is a matter of judicial restraint. *Florida v. HHS*, 780 F. Supp. 2d at 1299; *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) ("*Free Enterprise Fund*"). Courts honor separation-of-powers principles by carefully severing flawed statutes while leaving the remainder intact. But if the court must carve up, rearrange, and rewrite too much, then it is best to invalidate the entire scheme. The Eleventh Circuit recognized these fundamental principles governing severability (*Florida v. HHS*, 648 F.3d 1235, 1321 (11th Cir. 2011) but failed to apply them correctly in this case.

Severability dates back to *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803), where this Court shaved one unconstitutional section from the Judiciary Act of 1789 and left the rest of the Act intact. C. Vered Jona, *Note: Cleaning Up for Congress: Why Courts Should Reject the Presumption of Severability in the Face of Intentionally Unconstitutional Legislation*, 76 Geo. Wash. L. Rev. 698, 701 (April 2008) ("*Cleaning Up*"); David H. Gans, *Severability as Judicial Lawmaking*, 76 Geo. Wash. L. Rev. 639, 661-62 (2008) ("*Judicial Lawmaking*"). Over the next few decades, this Court explained that severance is appropriate unless it would disrupt legislative intent. *Bank of Hamilton v. Lessee of Dudley*, 27 U.S. (2 Pet.) 492, 526 (1829) ("If any part of the act be unconstitutional, the provisions of that part may be disregarded while full effect will be given to such as are not repugnant to the [C]onstitution...."); *Allen v. Louisiana*, 103 U.S. 80, 84 (1880) ("The point to be determined...is whether the unconstitutional provisions are so connected with the general scope of the law as to make it impossible, if they are stricken out, to give effect to what appears to have been the intent of the legislature.") Moreover, this Court began to warn against aggressive judicial revisions that effectively make new laws rather than enforcing old ones. *United States v. Reese*, 92 U.S. 214, 221 (1875); *Hill v. Wallace*, 259 U.S. 44, 70-71 (1922).

The "time-honored rule" now is "to sever with circumspection, severing any 'problematic portions while leaving the remainder intact.'" *Ayotte v. Planned Parenthood of New England*, 546 U.S. 320, 329 (2006) ("*Ayotte*"); *see also Free Enter. Fund*, 130 S. Ct. at 3161; *United States v. Booker*, 543 U.S. 220, 227-229 (2005); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) ("*Alaska Airlines*"); *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 591, 504 (1985); *Champlin Refining Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932) ("*Champlin*"); *El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909). Severability must be considered against the backdrop of separation-of-powers principles. Legislative intent is part of the equation, but courts must cautiously consider how much rewriting is necessary to save the statute. *Judicial Lawmaking*, 76 Geo. Wash. L. Rev. at 688.

The general principle favoring severability "is not a rigid and inflexible rule," particularly in a novel case like this one. *Florida v. HHS*, 780 F. Supp. 2d at 1299. The Act is invalid because it radically exceeds the powers of Congress and assaults the individual liberty that Americans treasure. But striking down *only* the individual mandate leaves the Act in shambles. Instead, this Court should eschew judicial rewriting and send Congress back to the drawing board with a clean slate.

A. This Court Cannot Conform The Act To The Constitution Without Performing Radical Surgery—A Quintessentially *Legislative* Function.

Severance is a remedial doctrine that shapes the contours of judicial relief after a court has found a statute unconstitutional in part. It requires courts to "restrain [themselves] from rewriting [a] law to conform it to constitutional requirements even as [they] strive to salvage it." *Ayotte,* 546 U.S. at 329-30, *Virginia v. Am. Booksellers Ass'n, Inc.,* 484 U.S. 383, 397 (1988). Conventional wisdom suggests that striking down the entire Act would be "more of an intrusion than severing [its] invalid parts." *Judicial Lawmaking*, 76 Geo. Wash. L. Rev. at 672. But like a Presidential veto, total invalidation "functions like a remand" to Congress (*id.* at 673) and protects the separation of powers by "preserv[ing] [the] court's role as an adjudicatory rather than a legislature body." *Cleaning Up*, 76 Geo. Wash. L. Rev. at 712. Reconfiguring this massive, 2700-page Act would be "a far more serious invasion of the legislative domain" than any court should undertake. *Ayotte,* 546 U.S. at 329-330. Such a feat would be "tantamount to rewriting a statute in an attempt to salvage it" *Florida v. HHS*, 780 F. Supp. 2d 1256, 1304 (N.D. Fla.

2011), "enmeshing the judiciary in policy choices...better left to the legislative branch." *Judicial Lawmaking*, 76 Geo. Wash. L. Rev. at 643.

The Act is not a series of short statutes arranged together for convenience and thus easily severed or fine-tuned, but rather a "carefully-balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal." *Florida v. HHS*, 780 F. Supp. 2d at 1299. The invalid mandate is the glue that holds the Act together. "There are simply too many moving parts in the Act and too many provisions dependent (directly and indirectly) on the individual mandate" to be able to carve it out without doing violence to the entire scheme. *Id.* at 1304. The mandate is a legislative lynchpin, inextricably bound to the whole. Sometimes the connection is obvious—the limited religious exemptions, employer mandates, and coverage that must be included in a minimum benefits package. Other provisions may or may not hinge on the individual mandate. As Judge Vinson noted, e.g., it is impossible to know whether the Form 1099 reporting requirement [Act § 9006]—a revenue generating provision—would "stand independently of the insurance reforms." *Id.* The Act "must stand or fall as a single unit." *Id.* at 1305.

The Eleventh Circuit complains that the plaintiffs failed to cite "any modern case where the Supreme Court found a legislative act inseverable." *Florida v. HHS,* 648 F.3d at 1321, n. 136. Maybe the plaintiffs missed some of the case law, but it does exist—and so does clear precedent holding that courts should eschew judicial rewriting. Recently this Court declined to "blue-pencil" legislation, noting some possibilities but leaving it to Congress to "pursue any of these options going forward." *Free Enterprise Fund,* 130 S. Ct. at 3162. This Court recognizes that it cannot "write words into [a] statute" or "leave gaping holes" or "foresee which of many different possible ways the legislature might respond to the constitutional objections" of a law it strikes down. *Randall v. Sorrell*, 548 U.S. 230, 262 (2006). In a pair of cases in the mid-1990's, "the Court declined to sever, reasoning that the legislature was the proper body to fix the respective statute's defects given the lack of a clear line in the statute to use for severance and the complexity of policy issues raised." *Judicial Lawmaking*, 76 Geo. Wash. L. Rev. at 647 n. 38, citing *Reno v. ACLU*, 521 U.S. 844 (1997) and *United States v. National Treasury Emps. Union*, 513 U.S. 454 (1995). In *National Treasury Employees Union*, this Court refused to craft a new "nexus requirement" when considering an honoraria ban applied to federal employees, finding that would involve "a far more serious invasion of the legislative domain" than the simple fix applied in *United States v. Grace*, 461 U.S. 171 (1983). *Id.* at 479 n. 26. In *Grace*, severance was an appropriate quick-fix that did not necessitate intrusive judicial rewriting or distort the statutory scheme. This Court struck down a ban on expression in the Supreme Court building and grounds, but only as applied to public sidewalks around the Court. *United States v. Grace*, 461 U.S. at 180-183. This was more efficient than requiring Congress to pass new legislation and it did not sacrifice the legislature's policy judgment. *Judicial Lawmaking*, 76 Geo. Wash. L. Rev. at 668.

A workable system of government is bound to create some overlap in the branches of government rather than a strict, inflexible separation. *Judicial Lawmaking*, 76 Geo. Wash. L. Rev. at 653; Paul M. Bator, *Constitution as Architecture: Legislative and Administrative Courts Under Article III*, 65 Ind. L.J. 233, 265 (1990). But courts must avoid encroaching on legislative territory. "Severance should rarely, if ever, be employed if radical surgery is necessary to save a statute." *Judicial Lawmaking*, 76 Geo. Wash. L. Rev. at 689. Here, removal of the individual mandate would impermissibly entangle the Court in legislative alterations beyond the judicial domain.

B. The Presumption Of Severability Should Be Abandoned Because Congress Had Knowledge Of The Act's Constitutional Flaws.

Legislators take an oath to "support [the] Constitution." U.S. Const. art. VI. But in spite of this duty:

> Congress occasionally passes legislation that even supporters acknowledge poses serious constitutional concerns and presidents sometimes support legislation they believe to be constitutionally dubious, all because they sense that the courts are available as the ultimate arbiter of constitutional disputes.

Michael D. Shumsky, *Severability, Inseverability, and the Rule of Law*, 41 Harv. J. on Legis. 227, 277 (2004) (citing Joel Mowbray, The Bush Way of Compromise, Wash. Times, Apr. 12, 2002, at A23). Legislators are obligated to evaluate the constitutionality of proposed legislation. Paul Brest, *The Conscientious Legislator's Guide to Constitutional Interpretation*, 27 Stan. L. Rev. 585, 586-587 (1975); *Cleaning Up*, 76 Geo. Wash. L. Rev. at 713.

This case is a striking example of legislators flouting their constitutional oath. Instead of examining the constitutional implications, this "2,700 page bill was rushed to the floor for a Christmas Eve vote." *Commonwealth of Va. v. Sebelius*, 728 F. Supp. 2d 768, 789 (E.D. Va. 2010). Before the last-minute rush to legislate, several states passed laws declaring the mandate unconstitutional and exempting their own state residents from it. Congress' own attorneys "advised that the challenges might well have legal merit as it was 'unclear' if the individual mandate had 'solid constitutional foundation.'" *Florida v. HHS*, 780 F. Supp. 2d at 1301; *see* Jennifer Staman & Cynthia Brougher, Congressional Research Service, Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis, July 24, 2009, at 3, 6 ("whether Congress can use its Commerce Clause authority to require a person to buy a good or a service" raises a "novel issue" and "most challenging question");[2] *see also Commonwealth of Va.*, 728 F. Supp. 2d 768. A severability clause included in an early version of the Act was ultimately excluded. *Florida v. HHS*, 780 F. Supp. 2d at 1301. Thus there is strong evidence that Congress deliberately demanded inclusion of the controversial mandate—aware of its questionable constitutionality.

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[2] Available at http://assets.opencrs.com/rpts/R40725_20090724.pdf.

Under these circumstances, the normal presumption of severability should be turned on its head.

Severability is presumptively appropriate when a law is partly unconstitutional. This allows legislators to pass laws without being held to a standard of perfection, knowing that "courts will not throw out the baby with the bath water." *Cleaning Up*, 76 Geo. Wash. L. Rev. at 654. But sometimes inseverability is the norm: the Establishment Clause (an improper purpose permeates all of a statute's applications), the Free Speech Clause (chilling effects test), and Equal Protection (underinclusivity). *Id.* at 705 n. 42.

It makes sense to extend the presumption of inseverability to cases where Congress has purposely included a constitutionally defective statute in a legislative scheme. *Cleaning Up*, 76 Geo. Wash. L. Rev. at 700. A presumption of inseverability would discourage judicial redrafting. It would also "increase legislators' accountability for the constitutional ramifications of their actions" and encourage them to draft constitutional laws. *Id.*

This Court should "send the [Act] back to [Congress] to redraft and renegotiate a constitutionally sound law." *Cleaning Up*, 76 Geo. Wash. L. Rev. at 712. Congress—having abdicated its obligation to follow the Constitution—should not be able to rely on the courts to repair its defective handiwork. *Id.* at 713-714, citing Michael C. Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. 235, 293 (1994).

II. THIS COURT SHOULD STRIKE DOWN THE ENTIRE ACT BECAUSE SEVERANCE WOULD THWART THE OBJECTIVES OF CONGRESS IN ENACTING IT.

When a court strikes down a statute as a remedial measure, it "frustrates the intent of the elected representatives of the people." *Ayotte,* 546 U.S. at 329-330. Courts use severance to avoid circumventing the legislature's intent. *Id.* But in this case, severance would frustrate that intent. Two District Courts correctly found the individual mandate unconstitutional, but the Virginia Court District, and the Eleventh Circuit on appeal from the Florida decision, left a shredded legislative scheme in place by failing to strike the entire Act.

Critical questions about legislative intent must be addressed:

- Would Congress have passed the Act without the individual mandate?

- Would Congress prefer a truncated Act—or no statute at all?

- If the mandate is severed:

    - Can the remaining provisions function independently and remain fully operative as law?

    - Would the remaining provisions still serve congressional intent, or would the purpose of the Act be defeated?

See Free Enterprise Fund, 130 S. Ct. at 3161-3162; *Booker*, 543 U.S. at 246; *New York v. United States*, 505 U.S. 144, 186 (1992); *Ayotte*, 546 U.S. at 330; *Alaska Airlines*, 480 U.S. at 684; *Buckley v. Valeo*, 424 U.S. 1, 108-109 (1976); *Champlin*, 286 U.S. at 234; *Allen*, 103 U.S. at 83-84. The Eleventh Circuit acknowledges these critical inquiries (*Florida v. HHS*, 648 F.3d at 1324) but glossed over evidence that the mandate was the cornerstone of the entire Act.

A. It Is Virtually Certain That Congress Would Not Have Passed The Act Without The Individual Mandate.

Language in the Act itself exposes congressional intent: "The [individual mandate] is essential to creating effective health insurance markets...." Act § 1501(a)(2)(I). As the Florida Court observed in its analysis of the Necessary and Proper Clause, Congress actually created the financial "necessity" it now employs to justify the mandate:

> [R]ather than being used to implement or facilitate enforcement of the Act's insurance industry reforms, *the individual mandate is actually being used as the means to avoid the adverse consequences of the Act itself*. Such an application of the Necessary and Proper Clause would have the perverse effect of enabling Congress to pass ill-conceived, or economically disruptive statutes, secure in the knowledge that *the more dysfunctional the results of the statute are, the more essential or "necessary" the statutory fix would be*.

Florida v. HHS, 780 F. Supp. 2d at 1297 (emphasis added). The Government reasons that its Commerce Clause power to regulate and reform the health *insurance business* allows it to compel *individuals* to purchase policies from the insurance companies subject to the new regulations, in order to make the law financially viable and prevent economic catastrophe. This reasoning is flawed. The Government's warped application of the Necessary and Proper Clause converts it to the "hideous monster with devouring jaws" that Hamilton assured us it was not, rather than the "perfectly harmless" part of the Constitution he assured us it was. *Id*. at 1298, citing The Federal No. 33, at 204-205. But Congress's insistence on the necessity of the mandate, and its resort to the Necessary and Proper Clause, implies that the mandate is inseverable. Although constitutionally improper, it is integral to the statutory scheme.

Severance would be appropriate if the legislature's goals would still be served. *New York*, 505 U.S. at 187. A relatively unimportant, uncontroversial provision is normally severable. *Alaska Airlines,* 480 U.S. at 694 n. 18, 696 (duty-to-hire provisions severed from unconstitutional administrative regulations). But where the legislature clearly would *not* have enacted the leftover portions without a lynchpin provision, severance is improper.

In spite of overwhelming evidence, the Virginia District Court found this "element of the analysis...difficult to apply...given the haste with which the final version of the 2,700 page bill was rushed to the floor for a Christmas Eve vote." The Court concluded that:

> It would be virtually impossible within the present record to determine whether Congress would have passed this bill, encompassing a wide variety of topics related and unrelated to heath care, without Section 1501.
>
> [W]ithout the benefit of extensive expert testimony and significant supplementation of the record, this Court cannot determine what, if any, portion of the bill would not be able to survive independently.

Commonwealth of Va., 728 F. Supp. 2d at 789.

This District Court's conclusion is strange in light of an avalanche of authority—including some of its own analysis. Recent decisions confirm the centrality of the individual mandate. *Id.* at 776 (The mandate is a "necessary measure to ensure the success of its larger reforms of the interstate health insurance market...without full market participation, the financial foundation supporting the health care system will fail, in effect causing the entire health care regime to 'implode.'"); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 886 (E.D. Mich. 2010) (mandate is "[i]ntegral to the legislative effort" and an "essential part of this larger regulation of economic activity"); *Florida v. United States Dep't of Health and Human Servs.*, 716 F. Supp. 2d 1120, 1129 (N.D. Fla. 2010) ("[The mandate] is necessary...to meet 'a core objective of the Act'"); *Florida v. HHS*, 780 F. Supp. 2d at 1298 ("...individual mandate is absolutely 'necessary' and 'essential' for the Act to operate as it was intended by Congress"); *id.* at 1301 ("indisputably essential to what Congress was ultimately seeking to accomplish"); *id.* ("[T]he defendants have conceded that the Act's health insurance reforms cannot survive without the individual mandate...."); *Liberty Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611, 633, 644-645 (W.D. Va. 2010) (mandate is essential to the Act); *Goudy-Bachman v. U.S. Dep't of Health & Human Servs.*, 764 F. Supp. 2d 684, 687 (M.D. Pa. 2011) ("backbone provision").

However misguided the reasoning or constitutional analysis, congressional intent is clear: The mandate is mandatory—the Act unravels without it.

B. Even If The Remaining Provisions Could Function Independently—A Truncated Act Would Not Serve Congressional Purposes.

It is a closer question as to whether the remaining provisions could function independently:

> In a statute that is approximately 2,700 pages long and has several hundred sections—certain of which have only a remote and tangential connection to health care—it stands to reason that some (perhaps even most) of the remaining provisions can stand alone and function independently of the individual mandate.

Florida v. HHS, 780 F. Supp. 2d at 1300. But the more critical inquiry is "whether these provisions will comprise a statute that will function 'in a manner consistent with the intent of Congress.'" *Id.*, quoting *Alaska Airlines*, 480 U.S. at 685. A court must proceed cautiously, not "us[ing] its remedial powers to circumvent the intent of the legislature." *Ayotte,* 546 U.S. at 330, citing *Califano v. Westcott,* 443 U.S. 76, 94

(1979) (Powell, J., concurring in part and dissenting in part).

Sometimes a legislative scheme can survive judicial surgery and continue to serve the legislature's purposes. *Free Enterprise Fund,* 130 S. Ct. at 3161 (Sarbanes-Oxley Act remained fully operative without tenure restrictions); *Reno*, 521 U.S. at 882-883 (the overbroad Communications Decency Act of 1996 could be salvaged by striking the words "or indecent"); *Alaska Airlines,* 480 U.S. at 684 (legislative veto easily severed from substantive provisions); *Brockett*, 472 U.S. at 506-507 (court could sever portion of overbroad state law mandating penalties for individuals dealing in obscenity and prostitution); *Tilton v. Richardson,* 403 U.S. 672, 684 (1971) (20-year limitation on religious use restrictions violated the Establishment Clause but was not essential to the statutory program). In *New York v. United States*, this Court severed a punitive "take title" provision without doing violence to the rest of the legislative scheme, which included independent incentives for States to dispose of radioactive waste. *New York*, 505 U.S. at 186-187.

This case is different. The Florida District Court correctly held that:

> [A]ny statute that might conceivably be left over...would plainly not serve Congress' main purpose and primary objective in passing the Act [health care reform].... The Act, like a defectively designed watch, needs to be redesigned and reconstructed by the watchmaker.

Florida v. HHS, 780 F. Supp. 2d at 1304-1305. The Florida Court declined to undertake the massive task of sorting through the Act's myriad provisions in order to salvage it. Instead, the Court suggested that Congress "do a comprehensive examination of the Act and make a legislative determination as to which of its hundreds of provisions and sections will work as intended without the individual mandate, and which will not." *Id.* at 1305.

C. The Absence Of A Severability Clause Weighs Against Preserving The Remaining Provisions.

A severability clause—if the Act contained one—would signal an intention to make the Act divisible. ***Champlin***, 286 U.S. at 235. But such a clause is not an "inexorable command." *Dorchy v. Kansas*, 264 U.S. 286, 290 (1924). It merely creates a "rebuttable presumption that 'eliminating invalid parts, the legislature would have been satisfied with what remained.'" *Welsh v. United States*, 398 U.S. 333, 364 (1970) (Harlan, J., concurring), quoting from *Champlin*, 286 U.S. at 235.

Severance, even on the legislature's cue, poses constitutional risks because it "enmeshes courts in what is quintessentially legislative policy work, and does so in a way that makes legislative correction unlikely after the fact." ***Judicial Lawmaking***, 76 Geo. Wash. L. Rev. at 687. Legislators may easily ignore constitutional norms in crafting laws, and courts may unwittingly create vague legal regimes in their efforts to salvage a partially unconstitutional scheme. *Id.* The line between the judicial and legislative branches may be dangerously thin.

On the other hand, the absence of a severability clause ordinarily "does not raise a presumption against severability." *Alaska Airlines,* 480 U.S. at 686; *New York*, 505 U.S. at 186. The omission does not necessarily "dictate the demise of the entire [Act]." *Tilton*, 403 U.S. at 684. The *Tilton* Court reasoned that:

> In view of the broad and important goals that Congress intended this legislation to serve, there is no basis for assuming that the Act would have failed of passage without this provision; nor will its excision impair either the operation or administration of the Act in any significant respect.

Id. at 684.

The Act does not contain a severability clause. Although there is no presumption, the omission constitutes evidence that severability was not a priority on the minds of legislators and logically presents a stronger case against severability than would exist if the clause had been included. Although the Eleventh Circuit faulted the District Court for its "undue emphasis on the lack of a severability clause" (*Florida v. HHS*, 648 F.3d at 1322), there is even more persuasive evidence against severability: A severability clause was included in an earlier draft of the Act but ultimately removed. *Florida v. HHS*, 780 F. Supp. 2d at 1301. The individual mandate was controversial during the drafting of the Act, and challenges were on the horizon. *Id.* The Florida District Court action was filed just minutes after the President signed the Act. *Id.* at 1263.

Even if the Act did contain a severability clause, that would not settle the issue. This Court first limited the enforcement of a severability clause nearly a century ago, finding the valid provisions of the Future Trading Act were "so interwoven with those [unconstitutional] regulations that they [could] not be separated." *Hill*, 259 U.S. at 70; *Cleaning Up*, 76 Geo. Wash. L. Rev. at 702. The Act under consideration here is similar—hundreds of detailed interrelated provisions.

Neither the presence nor the absence of a severability clause conclusively dictates the outcome. *United States v. Jackson*, 390 U.S. 570, 585 n.27 (1968) ("[The] ultimate determination of severability will rarely turn on the presence or absence of such a clause.") But the complexity of the Act, the multitude of interwoven provisions, Congress's knowledge of the Act's constitutional flaws, and the intentional removal of a severability clause all reinforce the wisdom of remanding the entire scheme to Congress. In fact, if a severability clause were invoked "to salvage parts of a comprehensive, integrated statutory scheme, which parts, standing alone, are unworkable and in many aspects unfair, [that would] exalt a formula at the expense of the broad objectives of Congress." *Buckley*, 424 U.S. at 255 (Burger, C.J., dissenting). In the absence of such a clause, it is all the more appropriate to steer clear of dissecting this mammoth piece of legislation.

CONCLUSION

This Court should strike down the entire Act rather than to sever the individual mandate and uphold a truncated version that Congress surely would not have passed.

Respectfully Submitted,

James L. Hirsen
Counsel of Record
505 S. Villa Real Drive
Suite 208
Anaheim Hills, CA 92807
(714) 283-8880
hirsen@earthlink.net

Deborah J. Dewart
620 E. Sabiston Drive
Swansboro, NC 28584
(910) 326-4554
debcpalaw@earthlink.net

Counsel for Amicus Curiae

AMICUS
CURIAE
BRIEF

No. 11-400

IN THE

Supreme Court of the United States

◆

STATE OF FLORIDA, *ET AL.*,

Petitioners,

—v.—

UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF OF *AMICI CURIAE* THE LEADERSHIP CONFERENCE ON CIVIL AND HUMAN RIGHTS, ASIAN AMERICAN LEGAL DEFENSE AND EDUCATION FUND, NATIONAL AIDS HOUSING COALITION, NATIONAL ECONOMIC AND SOCIAL RIGHTS INITIATIVE, NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL, NATIONAL LAW CENTER ON HOMELESSNESS & POVERTY, POVERTY & RACE RESEARCH ACTION COUNCIL, URBAN JUSTICE CENTER AND WILD FOR HUMAN RIGHTS IN SUPPORT OF RESPONDENTS REGARDING MEDICAID EXPANSION

MARTHA F. DAVIS*†
MARGARET WOO
PROGRAM ON HUMAN RIGHTS
AND THE GLOBAL ECONOMY
NORTHEASTERN UNIVERSITY
SCHOOL OF LAW
400 Huntington Avenue
Boston, Massachusetts 02115
(617) 373-8921
m.davis@neu.edu

RISA E. KAUFMAN
HUMAN RIGHTS CLINIC
COLUMBIA LAW SCHOOL
435 W. 116th Street
New York, New York 10027
(212) 854-0706

**Counsel of Record*
†Admitted in New York and Illinois

Counsel for Amici Curiae

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INTEREST OF AMICI CURIAE

Amici Curiae file this brief in support of Respondents. The statements of interest of *Amici Curiae* are set forth in the Appendix. [1]

SUMMARY OF ARGUMENT

The Medicaid Expansion Provision reflects an effort on the part of Congress to make health care coverage available to millions of low-income individuals, and thereby mitigate racial disparities in access to health care within the United States. As such, the Medicaid Expansion Provision squarely addresses concerns raised on repeated occasions by international human rights bodies, United Nations experts and the wider international community and represents an important step towards bringing the United States into compliance with its international treaty obligations to end racial discrimination in healthcare access, including commitments made in ratifying the International Convention on the Elimination of All Forms of Racial Discrimination and the International Covenant on Civil and Political Rights. Indeed, in both international and domestic settings, the United States government has pointed to the Medicaid Expansion Provision as evidence of its commitment to address racial disparities in access to health care, abide by its international human rights commitments, and advance the nation's global credibility on nondiscrimination in health care. This international context should inform the Court's consideration of the Medicaid Expansion Provision's constitutionality.

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[1] Pursuant to Rule 37.3, letters of consent to the filing of this brief have been submitted to the Clerk of the Court. Pursuant to Rule 37.6, counsel for *amici* states that no counsel for a party authored this brief in whole or in part and none of the parties or their counsel, nor any other person or entity other than *amici*, their members or counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

ARGUMENT

I. The International Context of the ACA is Relevant to This Court's Consideration of the Constitutionality of the Medicaid Expansion Provision

Beginning in 2014, eligibility for Medicaid shall extend to certain individuals with incomes up to 133 percent of the federal poverty level. 42 U.S.C. 1396a(a)(1)(A)(i)(VIII) (Supp. IV 2010) [hereinafter the Medicaid Expansion Provision of The Patient Protection and Affordable Care Act, Pub. 1, No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. 1 No. 111-152, 124 Stat. 1029 [hereinafter the Affordable Care Act]].

While the Medicaid Expansion Provision is most certainly a domestic U.S. law, its enactment and subsequent judicial consideration take place in an international context, including relevant international law to which the U.S. is a party, and considerable interest from the international community. Consideration of this international context of the Medicaid Expansion Provision would continue a "longstanding practice" of this Court to look beyond our nation's borders for support for its conclusions. *Graham v. Florida*, 130 S. Ct. 2011, 2033 (2010); *see also* Sarah H. Cleveland, *Our International Constitution*, 31 Yale J. Int'l L. 1, 88 (2006) (describing this Court's cases as demonstrating "a longstanding tradition of relying on international law to inform constitutional meaning").

This Court has referred to international authority as "instructive for its interpretation" of federal law. *Roper v. Simmons*, 543 U.S. 551, 575 (2005); *see Abbott v. Abbott*, 130 S. Ct. 1983, 1993-94 (2010) (drawing on the views of sister signatories to a treaty, international case law, and international consensus to inform the Court's conclusion); *see also Grutter v. Bollinger*, 539 U.S. 306, 344 (2003) (Ginsburg, J., concurring) (describing the International Convention on the Elimination of All Forms of Racial Discrimination as instructive on the scope of affirmative government actions with respect to racial equality). Further, consistency between the Court's interpretation and international agreements "demonstrates that the Court's rationale has respected reasoning to support it." *Graham*, 130 S. Ct. at 2034.

II. The Medicaid Expansion Provision Furthers U.S. Compliance with its International Human Rights Treaty Obligations to Ensure Equality in Access to Adequate Health Care Regardless of Race

A. International Bodies and Experts Have Noted Concern Over Racial Disparities in Access to Health Care in the U.S.

In 1994, the U.S. ratified the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), agreeing to "undertake to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of... [t]he right to public health [and] medical care." Convention on the Elimination of All Forms of Racial Discrimination art. 5(e)(iv), *opened for signature* Dec. 21, 1965, S. Exec. Doc. C, 95-2 (1978), 660 U.N.T.S. 195.[2] *See also* CERD General Recommendation No. 34 on Racial Discrimination Against People of African Descent, CERD/C/GC/34 (Oct. 3, 2010), ¶¶ 50, 55 (recommending that State parties remove obstacles to enjoyment of right to health as well as ensure equal access to health care for people of African descent).

With ratification of the treaty, the U.S. agreed to submit periodic reports to the CERD Committee, the United Nations body charged with monitoring state compliance with the Convention.[3] CERD, art.

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[2] In ratifying CERD the United States attached an understanding setting forth a division of labor between federal, state and local government for domestic implementation. 140 Cong. Rec. 14326 (daily ed. June 24, 1994) (U.S. Reservations, Declarations, and Understandings, International Convention on the Elimination of All Forms of Racial Discrimination). The record notes that the United States would implement the Convention "to the extent that it exercises jurisdiction over the matters covered therein, otherwise by the state and local governments. To the extent that state and local governments exercise jurisdiction over such matters, the Federal Government, shall, as necessary, take appropriate measures to ensure the fulfillment of this Convention." *Id.* § III. *See also* 138 Cong. Rec. S4781 (daily ed. Apr. 2, 1982) (same understanding regarding International Covenant on Civil and Political Rights).

[3] An obligation that a country accepts when it ratifies a human rights treaty is periodic review by the international committee

9.1. On each occasion that the CERD Committee has conducted such a review, it has held the U.S. to its international obligations and has communicated to the U.S. its concern about the high levels of racial inequality in access to health care in the U.S.

In 2001, commenting on the U.S.'s first set of submissions concerning its compliance with CERD, the CERD Committee specifically noted its concern "about persistent disparities in the enjoyment of, in particular, . . . access to public and private health care." U.N. Comm. on the Elimination of Racial Discrimination, Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America, ¶ 19, U.N. Doc. CERD/C/59/Misc.17/Rev.3 (Aug. 13, 2001).

Reviewing the U.S.'s next submission, in 2008, the CERD Committee again noted its concern, this time in greater detail. Observing "that a large number of persons belonging to racial, ethnic and

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of independent experts charged with monitoring treaty compliance ("the treaty body"). As part of the review, the country must submit a comprehensive report on progress that it has made towards implementing its treaty commitments. *See* Compilation of Guidelines on the Form and Content of Reports to be Submitted by States Parties to the International Human Rights Treaties, U.N. Doc. HRI/GEN/2/Rev.6 (June 3, 2009). At the conclusion of the treaty review, the treaty body issues a set of concluding recommendations highlighting specific areas of concern. Office of the U.N. High Commissioner for Human Rights, The United Nations Human Rights Treaty System: An Introduction to the Core Human Rights Treaties and the Treaty Bodies, Fact Sheet No. 30, (June 2005), pp. 21-23.

national minorities still remain without health insurance and face numerous obstacles to access to adequate health care and services," the Committee specifically recommended that the U.S. take steps to eliminate "the obstacles that currently prevent or limit [racial, ethnic and national minorities'] access to adequate health care, such as lack of health insurance, unequal distribution of health care resources, persistent racial discrimination in the provision of health care and poor quality of health care services." U.N. Comm. on the Elimination of Racial Discrimination, Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America, ¶ 32, U.N. Doc. CERD/C/USA/CO/6 (May 8, 2008).

United Nations independent experts have expressed concerns similar to those raised by the CERD Committee. The Independent Expert on Human Rights and Extreme Poverty made an official visit to the U.S. in 2005, invited by the U.S. government.[4] In his report, submitted to the U.N. Economic and Social Council, the Independent Expert noted the "significant disparity in uninsured rates between non-Hispanic Whites (11.3 per cent), African Americans (19.7 per cent) and Hispanics (32.7 per cent)," and the "deep inequalities linked to income, health insurance coverage, race, ethnicity, geography and critically-[needed] access to care." U.N. Independent Expert on Human Rights and Extreme Poverty, Report on Mission to the United States, ¶¶ 32-33, U.N. Doc. E/CN.4/2006/43/Add.1 (March 27, 2006). The Independent Expert concluded that in the U.S., "[i]nequality in the health outcomes are staggering" and urged expansion of the social safety net as one approach to reducing these impacts. *Id.* at ¶¶ 33, 81.

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[4] Independent Experts under the purview of the U.N. make official country visits only upon an invitation from the government. *See* Office of the U.N. High Commissioner for Human Rights, *Special Procedures of the Human Rights Council*, http://www2.ohchr.org/english/bodies/chr/special/index.htm (last visited Feb. 9, 2012).

Similar concerns were raised in 2010, during a visit to the United States by the U.N. Working Group of Experts on People of African Descent, a group established in 2002 by the predecessor to the U.N. Human Rights Council. *See* Office of the U.N. High Commissioner for Human Rights, *Working Group of Experts on People of African Descent*, http://www2.ohchr.org/english/issues/racism/groups/african/4african.htm (last visited Feb. 9, 2012). The Working Group found that access to health care is an issue of great importance to people of African descent in the United States, and based on a detailed review of relevant data, that "health disparities between people of African descent and the white population continue to be of concern." U.N. Human Rights Council, Working Group of Experts on People of African Descent, Report on Visit to the United States of America from 25 to 29 January 2010, ¶ 38, U.N. Doc. A/HRC/15/18 (Aug. 6, 2010). The Working Group identified several health issues that are problematic from a racial standpoint, including the fact that "minorities in the U.S. are less likely than whites to receive needed care." *Id.* at ¶ 79.

B. Responding to International Concern, the United States Has Repeatedly Cited the ACA to Demonstrate U.S. Progress Toward Meeting Its International Obligations and Ensuring Equal Access to Health Care Regardless of Race

Since the ACA's enactment on March 23, 2010, the U.S. has repeatedly cited this legislation – of which the Medicaid Expansion Provision is a key component -- as a response to these international concerns and as evidence of U.S. progress toward meeting its international human rights treaty obligations to achieve racial equality in the enjoyment of public health and medical care. These Executive branch statements concerning the nature of U.S. treaty obligations and the ways in which they are served by the ACA are entitled to "great weight." *Abbott*, 130 S. Ct. at 1993 (citation omitted) (noting that the Court's conclusion was "supported and informed by the State Department's view on the issue"); *see Sumitomo Shoji America, Inc. v. Avagliano*, 457 U.S. 176, 184 n.10 (1982) (deferring to the Executive branch's interpretation of a treaty as memorialized in a brief before the Court).

For example, the United States' report to the U.N. Human Rights Council in conjunction with the Universal Periodic Review, submitted on August 23, 2010 ("the UPR Report"), cites the ACA as evidence of the nation's commitment to reduce discrimination in access to health care and health insurance in accordance with its international obligations.[5] *See* National Report Submitted in Accordance with Paragraph 15(a) of the Annex to the Human Rights Council Resolution 5/1, United States of America, ¶¶ 70-73, U.N. Doc A/HRC/WG.6/9/USA/1 (Aug. 23, 2010). Acknowledging the alarming disparities in health between minorities and the white population, the U.S. government's UPR Report specifically notes that the ACA will "help our nation reduce disparities and discrimination in access to care that have contributed to poor health."[6] *Id.* at ¶ 71.

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[5] The Universal Periodic Review (UPR) is a mechanism, created by the U.N. General Assembly in 2006 along with the U.N. Human Rights Council, by which the Human Rights Council facilitates an intergovernmental review of the human rights record of each U.N. member state. U.N. General Assembly, Resolution, 60/251, Human Rights Council, U.N. Doc. A/RES/60/251 (Apr. 3, 2006); U.N. Human Rights Council, Institution-Building of the United Nations Human Rights Council (June 18, 2007). The United States' first UPR occurred in 2010.

[6] For example, the report notes that African Americans are 29 percent more likely to die from heart disease than non-Hispanic whites. Asian American men suffer from stomach cancer 114 percent more often than non-Hispanic white men. Hispanic women are 2.2 times more likely to be diagnosed with cervical cancer than non-Hispanic white women. American Indians and Alaska Natives are 2.2 times as likely to have diabetes as non-Hispanic whites. Additionally, these racial and ethnic groups accounted for almost 70 percent of the newly diagnosed cases of HIV and AIDS in 2003. UPR Report at ¶ 71, *citing* U.S. Dep't of Health and Human Services, Office of Minority Health, *Protecting the Health of Minority Communities* (2006), *available at* http:// www.hhs.gov/news/factsheet/minorityhealth.html.

The U.S. State Department's Legal Adviser, Harold Koh, underscored this assertion in remarks formally responding to the recommendations of the U.N. Human Rights Council that resulted from the UPR. In particular, the Legal Adviser cited the "recent landmark healthcare reform" as the latest example of a U.S. federal program established to "empower our citizens to live what FDR called a 'healthy peacetime life.'" Harold Hongju Koh, *Response of the United States of America to Recommendations of the United Nations Human Rights Council*, U.S. Dep't of State (Nov. 9, 2010), http://www.state.gov/s/l/releases/remarks/150677.html.

In December 2011, the U.S. government cited the ACA in its periodic report to the U.N. Human Rights Committee concerning U.S. compliance with its commitments under provisions of the International Covenant on Civil and Political Rights ("ICCPR"). *See* Fourth Periodic Report of the United States of America to the United Nations Human Rights Committee Concerning the International Covenant on Civil and Political Rights, ¶¶ 27, 44, 88, 90, 434, 498, U.N. Doc. CCPR/C/USA/4 (Dec. 30, 2011) [hereinafter ICCPR Report]. Like CERD, the ICCPR has been ratified by the U.S.; Article 2 of the ICCPR obligates each state party to adhere to principles of nondiscrimination on the basis of race as well as other grounds. *See* International Covenant on Civil and Political Rights art. 2, *opened for signature* Dec. 16, 1966, S. Exec. Doc. E, 95-2 (1978), 999 U.N.T.S. 171. The U.S. government's ICCPR Report notes that the ACA addresses "concerns regarding racial and ethnic disparities in healthcare access" and intimates that the Medicaid Expansion Provision specifically furthers U.S. efforts to provide all children adequate health care. *See* ICCPR Report at ¶¶ 90, 434-35.

Finally, speaking in a domestic forum and training his remarks toward an international audience, in March 2011, Assistant Secretary of State for Democracy, Human Rights, and Labor Michael Posner articulated the U.S. government's perspective that the ACA plays an important role in establishing the nation's international leadership on access to health care, asserting that

> Our government's commitment to provide for the basic social and economic needs of our people is clear, and it reflects the will of the American people. The people ask us to care for the sick ... and we do. In 2009, our nation spent nearly $900 billion on Medicare and Medicaid. And as you know, last year the administration passed and signed the Affordable Care Act to expand access to health care in America.

Michael Posner, Assistant Secretary of State for Human Rights, Democracy and Labor, *The Four Freedoms Turn 70: Ensuring Economic, Political, and National Security in the 21st Century*, Annual Meeting of the American Society of International

Law, Washington, D.C., March 24, 2011, *available at* http://www.state.gov/j/drl/rls/rm/2011/159195.htm.

C. Congress Intended the Medicaid Expansion Provision to Help Alleviate Racial Disparities in Health Care Access

The ameliorative impact of the Medicaid Expansion Provision is not simply a byproduct of other choices made in the legislative process, but was an important consideration in Congressional enactment of the measure as part of the Affordable Care Act.

As an initial matter, it is well documented that the number of people of color who live at the poverty level and qualify for Medicaid is disproportionate to their representation in the general population. *See, e.g.*, U.S. Dep't of Health and Human Services, Office of Minority Health, African American Profile, *available at* http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=51 ("In 2010, the U.S. Census Bureau reported that 27.4 percent of African-Americans in comparison to 9.9 percent of non-Hispanic Whites were living at the poverty level... [and] 28 percent of African-Americans in comparison to 11 percent of non-Hispanic Whites relied on Medicaid, public health insurance."); U.S. Dep't of Health and Human Services, Office of Minority Health, American Indian/Alaska Native Profile, *available at* http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=52 (28 percent of American Indians and Alaska Natives live at the poverty level and 30 percent of American Indians and Alaska Natives relied on Medicaid coverage); U.S. Dep't of Health and Human Services, Office of Minority Health, Hispanic/Latino Profile, *available at* http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=54 (26.6 percent of Hispanics living at the poverty level and 30.3 percent of Mexicans, 39.8 percent of Puerto Ricans, 31.6 percent of Cubans, and 26.8 percent of other Latino groups relied on public health coverage).

Racial and ethnic minorities also disproportionately lack health insurance. The Centers for Disease Control (CDC) estimates that "[a]pproximately two of every five persons of Hispanic ethnicity and one of five non-Hispanic blacks were classified as uninsured during both 2004 and 2008." Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, CDC Health Disparities and Inequalities Report – United States, 2011, Supp./Vol. 60, (Jan. 14, 2011), at 35, *available at* http://www.cdc.gov/mmwr/pdf/other/su6001.pdf. According to the CDC, "[b]oth these groups had significantly higher uninsured rates... compared with... non-Hispanic whites." *Id.* Because ethnic and racial minorities tend to have lower incomes, the Medicaid Expansion Provision will have an "enormous impact on helping them afford coverage." American Diabetes Ass'n et al., *Medicaid: A Lifeline for Blacks and Latinos With Serious Health Care Needs*, Oct. 2011, at 19-20.

Congress was well-aware of this anticipated impact of the Medicaid Expansion Provision as it considered the measure. Concerned organizations made certain that this information was part of the Congressional record. For example, Families, USA, a non-profit organization promoting high quality affordable health care for all Americans, in a hearing before the House Ways and Means Committee, stated that

> Hispanics/Latinos, African Americans, and people of other racial or ethnic minorities were much more likely to be uninsured than whites: 55.1 percent of Hispanics/Latinos, 40.3 percent of African Americans, and 34.0 percent of other racial and ethnic minorities went without health insurance in 2007-08, compared to 25.1 percent of whites.

Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs: Hearing Before the H. Comm. on Ways and Means, 111th Cong. 154 (2009) (statement of Families, USA).

Further, the statements of Members of Congress during the congressional debates of the ACA and its predecessor bills show that Congressional representatives were fully aware that the Medicaid Expansion Provision would be an important mechanism for increasing the access to medical care of people of color. Some members of Congress opposed the expansion arguing, as did Congressman Bill Cassidy, that Medicaid should not be made available to "more and more people." 156 Cong. Rec. H1461 (daily ed. March 16, 2010). The majority of Congress, however, ultimately supported the expansion and, for many members, the fact that it would remedy racial disparities was key.

For example, in an early debate, Representative Marcia Fudge observed that "nearly half -- or 48 percent -- of black adults suffer from some form of chronic condition compared to 39 percent of all adults," yet "one in every five black Americans lack health insurance compared to one in every eight whites." 155 Cong. Rec. H8397 (daily ed. July 20, 2009) (statement of Rep. Fudge). Representative Fudge continued, "Considering the statistics that I mentioned, I'm glad to report that affordability and access to quality health care are two problems that are addressed" by the Medicaid Expansion Provision of the then-pending health care reform bill. *Id.*

When the ACA reached the House floor, Congresswoman Nydia Velazquez noted that "Latinos have been left behind, suffering the highest uninsured rate of any other community," and asserted that "[f]or the Latino community, [the ACA] delivers coverage to 8.8 million people." 156 Cong. Rec. H1909 (daily ed. Mar. 21, 2010) (statement of Rep. Velazquez). Similarly, Congresswoman Donna Christensen observed that "[t]his year and every year past, over 80,000 African Americans died, whose deaths were preventable, because they were unable to get healthcare," and unequivocally stated that "this bill is for all people of color... and [will] finally begin to eliminate health disparities." 155 Cong. Rec. H12843 (daily ed. Nov. 7, 2009) (statements of Rep. Christensen). *See also* 156 Cong. Rec. H4407 (daily ed. June 14, 2010) (statement of Rep. Jackson Lee, comparing Congressional debate concerning the Medicaid Expansion Provision to earlier debates over the 1964 Civil Rights Act and the 1965 Voting Rights Act).

This understanding that the Medicaid Expansion Provision will ameliorate racial disparities has also been articulated by the Executive Branch as it prepares to implement the relevant provisions of the ACA. For example, the U.S. Department of Health and Human Services has created an action plan to reduce racial and ethnic health disparities. *See* U.S. Dep't of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, April 2011, *available at* http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. In support of its strategy to "reduce disparities in health insurance coverage and access to care," the action plan states that the Medicaid Expansion, among other ACA measures, "will have a focus on reducing disparities in coverage for racial and ethnic minorities." *Id.* at 15.

In sum, the enactment of the Medicaid Expansion Provision was an important and deliberate advance toward decreasing racial discrimination in access to health care. This action is entirely consistent with, and indeed furthers, the nation's international human rights treaty obligations to end racial discrimination in the enjoyment of equal access to public health care and medical care.

CONCLUSION

For the foregoing reasons, this Court should affirm the opinion of the Eleventh Circuit Court of Appeals upholding the Medicaid Expansion Provision of the ACA.

Respectfully submitted,

MARTHA F. DAVIS*†
MARGARET WOO
Program on Human Rights
and the Global Economy
Northeastern University
School of Law
400 Huntington Avenue
Boston, MA 02115
(617) 373-8921
m.davis@neu.edu

RISA E. KAUFMAN
Human Rights Clinic
Columbia Law School
435 W. 116th Street
New York, NY 10027
(212) 854-0706

**Counsel of Record*
† Admitted in New York and Illinois

APPENDIX

STATEMENTS OF INTEREST OF AMICI CURIAE

The **Leadership Conference on Civil and Human Rights** is the nation's oldest and largest civil and human rights coalition, consisting of more than 210 national organizations charged with promoting and protecting the rights of all persons in the United States. The Leadership Conference was founded in 1950 by A. Philip Randolph, head of the Brotherhood of Sleeping Car Porters; Roy Wilkins of the NAACP; and Arnold Aronson, a leader of the National Jewish Community Relations Advisory Council. The Leadership Conference works to build an America that is as good as its ideals. We use international human rights norms and standards to promote the elimination of racial disparities and advance equality and non-discrimination in the areas of health care, education, employment and criminal justice. We support the authority of Congress to enact legislation, such as the Patient Protection and Affordable Care Act, which increases Americans' access to quality health care. Through our shadow reports to the U.N. Committee on the Elimination of Racial Discrimination and participation in the Universal Periodic Review process, The Leadership Conference has advocated for U.S. accountability for its human rights obligations, specifically to provide access to and eliminate inequities in our health care system. The Medicaid Expansion Provision Affordable Care Act will lead to broader access to quality health care by the most vulnerable segments of society, including children, people of color, women, seniors, and people with disabilities. By addressing the huge disparities in both access to and quality of coverage and care, the Medicaid Expansion Provision takes a momentous step toward respecting, protecting and fulfilling the right of all Americans to secure affordable, high quality health care.

The **Asian American Legal Defense and Education Fund** (AALDEF), founded in 1974, is a national organization that protects and promotes the civil rights of Asian Americans. By combining litigation, advocacy, education, and organizing, AALDEF works with Asian American communities across the country to secure human rights for all. The Medicaid Expansion Provision of the Affordable Care Act is an important step in furtherance of the federal government's obligations under international human rights law and should be upheld.

The **National AIDS Housing Coalition** (NAHC) is an eighteen year old national membership nonprofit housing policy and advocacy organization. NAHC works to end the HIV/AIDS epidemic by ensuring that people with HIV/AIDS have quality, affordable and appropriate housing. NAHC compiles, synthesizes and disseminates research on the role of housing as the baseline for access to HIV health care and for effective HIV prevention interventions. Access to healthcare is of course essential for people with HIV/AIDS, and in the U.S. health insurance is central to the ability of people with HIV/AIDS to access and manage their illness. NAHC works with partners to advance the human rights frame for addressing HIV prevention and healthcare by fully globalizing research and policy discussions on the role of housing interventions as a response to the HIV/AIDS pandemic.

The **National Economic and Social Rights Initiative** (NESRI) advocates for U.S. accountability to international human rights norms, particularly with regard to health, education, housing and work with dignity. During the public debates leading to enactment of the Affordable Care Act, NESRI provided education and analysis for the public focusing on areas where ACA falls short of international norms by failing to make health care a public good available to all on equal terms, as well as where ACA brought the U.S. into greater compliance with those norms.

The **National Health Care for the Homeless Council** (NHCHC) is a non-profit membership organization representing Health Care for the Homeless (HCH) projects funded by the Health Resources and Services Administration, their staff, and the patients they serve. HCH projects provide primary medical care, behavioral health services, and other support services to individuals and families experiencing homelessness, 65% of whom are uninsured. Extending comprehensive health insurance to homeless persons is seen by NHCHC as a necessary (though insufficient) step toward realization of their human right to health care. For over 25 years, HCH projects have worked to remedy the poor access to health care services, disparities in health outcomes, and extraordinarily poor quality of life experienced by homeless persons. The Affordable Care Act will remedy some of these inequities by expanding health insurance coverage for poor people, and it is in the vital interests of homeless people and their health care providers that the statute be upheld.

The **National Law Center on Homelessness & Poverty** (NLCHP) is a nonprofit organization based in Washington, D.C. It was founded in 1989 with the mission to prevent and end homelessness by serving as the legal arm of the nationwide movement to end and prevent homelessness. To achieve its mission, NLCHP seeks to address the causes of homelessness, including the shortage of affordable housing, insufficient income, and inadequate social services, such as health care. NLCHP pursues three main strategies: impact litigation, policy advocacy, and public education. Health care and human rights are both central to NLCHP's mission and work. NLCHP views human rights as part of and integral to U.S. law, and incorporates it in all of its strategies. NLCHP participates actively in relevant international processes, and was active in the review of the United States through the CERD and UPR processes.

The **Poverty & Race Research Action Council** (PRRAC) is a civil rights policy organization based in Washington, D.C., committed to bringing the insights of social science research to the fields of civil rights and poverty law. PRRAC's research and advocacy work focuses on the racial impact of government policies in the areas of housing, education, and health. PRRAC is committed to the full domestic implementation of the Convention on All Forms of Racial Discrimination (CERD) and was instrumental in presenting a coalition report, *Unequal Health Outcomes in the United States: A Report to the U.N. Committee on the Elimination of Racial Discrimination* (January 2008) to the U.N. CERD Committee during its most recent periodic review of U.S. compliance with the treaty.

The **Urban Justice Center** (UJC) is a non-profit organization that serves poor New Yorkers through a combination of direct legal service, systemic advocacy, community education and political organizing. Our work defends the human rights of people who are often overlooked or turned away by other organizations, including the homeless; the mentally ill; domestic violence survivors; lesbian, gay, bisexual, and transgender youth; and people suffering human rights abuses caused by U.S. social welfare policies. UJC has worked to bring the United States into compliance with its human rights obligations in addressing race disparities including in access to healthcare.

WILD for Human Rights (WILD) is an initiative of the Miller Institute for Global Challenges and the Law at the UC Berkeley School of Law. Its mission is to promote human rights through the conscious leadership and action of women and girls, especially young women of color. With a vision of social and political change, it strives to improve the conditions of women and girls and their communities. WILD provides human rights education and training, engages in research and public advocacy, and collaborates on the adoption and implementation of international human rights standards in the United States and globally. This Court's consideration of how the principles of human rights would support the Medicaid Expansion Provision of the ACA and respond to racial disparities in access to medical care is therefore of significant interest to WILD.

AMICUS CURIAE BRIEF

Nos. 11-393 and 11-400

In the Supreme Court of the United States

National Federation of Independent
Businesses, *et al.*,
Petitioners,
v.

Kathleen Sibelius, Secretary of Health
and Human Services, *et al.*,
Respondents.

States of Florida, *et al.*,
Petitioners,
v.

Department of Health and Human
Services, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of
Appeals for the Eleventh Circuit

Amicus Brief of Michigan Legal Services, Inc. and Other Michigan Non-profit Corporations in Support of Government's Position on Medicaid

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MICHIGAN LEGAL SERVICES, INC.
GARY A. BENJAMIN, ESQ. (P 29103)
Counsel for *Amici*
220 Bagley, Suite 900
Detroit, MI 48226
Tel: (313) 590-6136
gbenjamin@michiganlegal.org.

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Introduction and Dedication

The Patient Protection and Affordable care Act [ACA hereinafter] expanded health care coverage in several ways. The major expansion is changing the Medicaid program to cover another 16 million people.

Our present system burdens ordinary Americans and does not deliver services to millions who need them. Bankruptcy, medical debt, and morbidity and mortality all increase in the system as it is now. This is especially true for those who are low income. Uninsured, low income people tend to avoid getting care until they need the hospital. At that point we all pay for their care through cost shifting. Sometimes it is too late and the patient dies. The Medicaid expansion would end this problem for all those at or below 133% of the Federal Poverty Level.

We dedicate this brief to those who have suffered under the present system – especially to the thousands who have died because they had no insurance and no access to affordable care.[1]

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[1] All parties have consented to this *Amicus curiae* brief and letters of consent have been filed with the Clerk. Pursuant to Rule 37.6, *Amici* represents that no counsel for a party authored this brief in whole or in part, and no person or entity other than *Amici* and its counsel made a monetary contribution to the preparation or submission of this brief.

Statements of Interest

Michigan Legal Services has represented persons at or below 200% of the Federal Poverty Level for over thirty years. The Affordable Care Act [ACA] significantly increases access to health insurance and health care to that population through many provisions of the ACA. We argue that the people we represent need the Medicaid expansion to live free, and productive lives.

MichUHCAN [Michigan Universal Health Care Access Network, Inc.] has been an advocate for people at all income levels. MichUHCAN is a grass roots organization with members throughout the State. MichUHCAN's members are often low income but significant numbers of them have lost their employer sponsored insurance and will be eligible for Medicaid in 2014.

Michigan Consumers for Healthcare represents more than 110 community and healthcare advocacy organizations, and works collaboratively with a diverse alliance of consumers, partners, and policymakers to attain affordable, accessible, quality healthcare for everyone in Michigan through education, outreach, advocacy and stakeholder engagement. MCH recognizes the Affordable Care Act (ACA) as the nation's most comprehensive healthcare reform effort in our history, presenting our best opportunity to make the vision of affordable, robust, and universal healthcare coverage a reality. ACA is a historic turning point in American healthcare, and its survival and implementation are crucial for the protection and advancement of consumer health.

The Center for Civil Justice is a non-profit law firm that advocates for low-income people in mid-Michigan who face challenges accessing basic human needs and services, including health care. In the area of health care, the Center's clients are uninsured or underinsured, low-income individuals and families who face difficulty qualifying for, or benefiting from, governmental healthcare programs like Medicaid and Medicare. In addition to direct legal representation of low income individuals and families, the Center works closely with private, non-profit human services providers throughout mid-Michigan that attempt to fill the gaps when low income individuals are uninsured or lack the health care coverage that they need to access necessary medical care. The Center receives a local grant to provide intensive advocacy and increase access to governmental health insurance programs for low income clients in Genesee County (Flint) Michigan.

The Medicaid expansion will cover more people than any other single provision of the ACA and all of those people covered are members of, or represented by, the *Amici*. Michigan Legal Services focuses on people at or below 200% of the Federal Poverty Level [FPL]. The Center for Civil Justice primarlily represents clients with incomes below 125% of the federal poverty level. Since the expansion covers people with incomes up to 138% of the federal poverty level, many of the people represented by

CCJ and MLS will gain coverage through this expansion alone.

The other two *Amici* also represent significant numbers of people in that income range. Given the huge drop in the number employer insured persons in Michigan, all organizations are concerned about the future and see the Medicaid expansion as a reasonable means for providing the health care security that was once provided by employers.

The Medicaid expansion affects everyone since it is the main safety net program for people who lose their employer sponsored coverage through some life changing event – a divorce; becoming widowed or a widower; losing a job; bankruptcy – this portion of the ACA is important to every working American who relies on his or her employer for health insurance coverage.

Summary of Argument

The ACA contains many 'moving parts' designed to correct a myriad of problems with our health care financing and delivery systems. The Medicaid expansion will provide coverage to more people than any other section of the ACA. To the extent any weighing of interests is relevant, the fact that the Medicaid expansion is so important to the security of all Americans should be taken into account.

The argument the states make is that this expansion is coercive and violates the 10th Amendment. To date no court has found a program under the spending clause unconstitutional using this theory.

Amici argue that the Medicaid provision of the ACA is not unconstitutional. We present the history of the Medicaid program in Michigan and point out that the state has historically sought to expand coverage under the program, including a historic effort under the last administration. Under the Medicaid program there is significant room for state control. The changes in Michigan's Medicaid program have included optional services; different qualifying levels of the Federal Poverty Limit (FPL); and failed efforts to increase coverage. Michigan has nine waivers, all designed to increase coverage.

In such a program, coercion is not the motivation. Getting services to the residents of the state is the motivation.

Argument: The Court of Appeals Ruling that the Medicaid Expansion under the ACA is not a violation of Congressional 'Spending Clause' powers should be affirmed.

The Eleventh Circuit describes the Medicaid expansion as follows:

> The Act expands Medicaid eligibility and subsidies by amending 42 U.S.C. § 1396a, the section of the Medicaid Act outlining what states must offer in their coverage plans. The Act imposes these substantive requirements on the states' plans, starting in 2014, unless otherwise noted:
>
>> (1) States will be required to cover adults under age 65 (who are not pregnant and not already covered) with incomes up to 133% of the federal poverty level ("FPL"). *Id.* § 1396a(a)(10)(A)(i)(VIII). This is a significant change, because previously the Medicaid Act did not set a baseline income level for mandatory eligibility. Thus, many states currently do not provide Medicaid to childless adults and cover parents only at much lower income levels.
>>
>> (2) States will be required to provide Medicaid to all children whose families earn up to 133% of the FPL, including children currently covered through

separate CHIP programs. *Id.* §§ 1396a(a)(10)(A)(i)(VII), 1396a(*l*) (1)(D), 1396a(*l*)(2)(C). States currently must provide Medicaid to children under age 6 with family income up to 133% of the FPL and children ages 6 through 18 with family income up to 100% of the FPL. *Id.* §§ 1396a(a)(10)(A)(i)(IV), (VI), (VII), 1396a(*l*)(1)(B)-(D), 1396a(*l*) (2)(A)-(C).

(3) States are required to at least maintain existing Medicaid eligibility levels for adults and children (that were in place as of March 23, 2010) until a state's Exchange is fully operational. *Id.* § 1396a(gg)(1). Whereas states previously had the option to raise or lower their eligibility levels, states cannot institute more restrictive eligibility standards until the new policies take place. *Id.*

(4) Children under age 26 who were receiving Medicaid but were "aged out" of foster care will be newly eligible to continue receiving Medicaid. *Id.* § 1396a(a)(10)(A)(i)(IX) (effective Jan. 1, 2014).

(5) The new law will increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rates for

> 2013 and 2014. *Id.* § 1396a(a)(13)(C). States will receive 100% federal funding for the cost of the increasing payment, rates for 2013 and 2014. *Id. Id.* § 1396a(a)(13)(C).

State of Florida et al. v. US Department of Health and Human Services, et al., 648 F.3d 1235 at 1261 – 2 (11th Cir. 2011).

This expansion is projected to cover about 16 million people by 2016 and is the single largest component of the increase in access to health coverage in the ACA.

All parties agree that Medicaid is a voluntary program. That is, the states could turn down the increase and stop participating in Medicaid. However, since the program's inception in 1965 every state has not only participated but all states have provided more benefits than the Medicaid program requires.

As the Eleventh Circuit notes, the Federal Government is providing 100% of the cost of this expansion until 2016 and will continue to provide 90% or more until 2020. If a state chooses the expansion it will be required to cover the administrative expenses only. *Op. cit.* at p. 1263. In Michigan, from 2001 through 2008 staffing for the Medicaid program increased a mere 6% while the appropriations to pay for the program and numbers of persons covered both increased over 40%.[2]

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[2] **FY Staffing Appropriation Persons**

The Court of Appeals relied on four factors in determining that the expansion was not unduly coercive. First, it notes that from the beginning states have had the chance to opt out of the Medicaid program, During the 45 year history of the program there have been several amendments and no state has opted out of those changes, even though at each occasion the states would be allowed to opt out. The Medicaid Act, nor any of its amendments, has ever been struck down as 'coercive. *Op. cit.* at p.1267.

Second, the Court notes that the federal government will absorb almost all of the costs. *Op. cit.* at p. 1267 – 8.

Third, the Court notes that the states have a long period of time to prepare for the expansion since it will not occur until 2014. *Op. cit.* at p 1268.

FY2001	**345.5**	**$5,520,288,600**	**1,117,600**
FY2002	**337.5**	**$5,603,010,000**	**1,211,800**
FY2003	**333.7**	**$6,258,195,300**	**1,293,200**
FY2004	**333.7**	**$6,316,394,600**	**1,366,200**
FY2005	**339.7**	**$6,817,057,100**	**1,430,100**
FY2006	**336.4**	**$6,809,271,100**	**1,475,800**
FY2007	**366.4**	**$7,298,137,800**	**1,540,440**
FY2008	**366.4**	**$8,131,847,700**	**1,581,000***
Change FY01-FY08			
	+6.0%	**+47.3%**	**+41.5%**

******Projected*

Source of Appropriations: Senate Fiscal Agency

Pressure on Medicaid Continues as Health Care Medical Needs Increase,MLHS, June, 2008.

Finally, the Court notes that the Petitioners are simply in error on one of their facts. Petitioners argued that the ACA requires that they would lose all of their Medicaid funding if they refused to accept the expansion. The court writes:

> . . . .nothing in the Medicaid Act states that this is a foregone conclusion. Indeed, the Medicaid Act provides HHS with the discretion to withhold all or merely a portion of funding from a noncompliant state. 42 U.S.C. § 1396c.

Op. cit. at p. 1268.

The court notes that new budgets and perhaps raising new revenue are choices states can make.

The Eleventh Circuit then ruled:

> Taken together, these factors convince us that the Medicaid-participating states have a real choice—not just in theory but in fact—to participate in the Act's Medicaid expansion. *See [South Dakota v.] Dole*, 483 U.S. [203] at 211, 107 S. Ct. at 2798. Where an entity has a real choice, there can be no coercion. *See Steward Mach [v. Davis]*, 301 U.S. [548] at 590, 57 S. Ct. at 892 (noting that in the absence of undue influence, "the law has been guided by a robust common sense which assumes the freedom of the will as a working hypothesis in the solution of its problems"). Accordingly, the district court's grant of

summary judgment to the government on the Medicaid expansion issue is affirmed.

State of Florida et al. v. US Department of Health and Human Services, et al., 648 F.3d 1235 at 1268 – 9 (11th Cir. 2011).

Michigan Medicaid History

Like its sister states, Michigan has covered many medical services not mandated under the Medicaid Act. These optional services include:

Prescription drugs
Clinic services
Most mental health services
Physical therapy
Occupational therapy
Speech, hearing and language disorder services
Respiratory care services
Other diagnostic, screening, preventive and rehabilitative services
Podiatry services
Optometry services (limited for adults)
Dental services
Dentures
Prosthetics and Orthotics
Eyeglasses (limited for adults)
Chiropractic services (not available for adults)
Hospice
Durable medical equipment and medical supplies

Other practitioner services (as medically necessary)
Private duty nursing services
Home and community-based long term care supports and services[3]

Optional services are often at risk when medical needs rise or when revenue drops. But eliminating these services is often more costly than keeping them, especially to the citizen.

> The elimination of Medicaid adult dental services, as well as the other federally defined "optional" services, is causing suffering and threatening the lives of the most vulnerable people in Michigan. Lower-cost prevention care is being sacrificed for questionable short term savings. Restoring these services could help keep Medicaid adult recipients healthy and save money in the long run.
>
> The July 1 elimination of dental benefits has already had severe consequences. Officials with a dental clinic treating an elderly developmentally disabled woman in Northern Michigan said her condition was complicated by a severe dental infection that they were not able to effectively treat because of the cancellation of dental benefits. She died Oct. 7 in an Alpena hospital.

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[3] List provided by Michigan League for Human Services.

> The family of another disabled Michigan man says he developed a serious oral infection. His teeth were so bad that they posed a risk of choking so they were pulled. Now the man has no ability to get dentures because of the lack of dental benefits. His food intake is limited without teeth and is threatening his health.
>
> In addition, the state of Michigan must defend a lawsuit filed on behalf of 400,000 Medicaid beneficiaries for the cancellation of dental benefits. The lawsuit contends that thousands of Michigan residents with marginal resources will be more vulnerable to debilitating and potentially life-threatening illnesses.
>
> Lower-cost dental services, as well as vision, chiropractic, and podiatric care are necessary to avoid complications that are expensive to treat in Michigan's emergency rooms or intensive care units.[4]

The States' argument assumes a false fact. That is that cuts in benefits actually save the state money. In Michigan, it is clear that the opposite is true in most instances. Cuts in basic services cost more money. Similarly, granting more basic services to more people will result in better health care and 'catching' problems earlier so that they may be treated at an earlier stage with less cost to the Medicaid program and much less cost to the recipient of services. The Petitioners' arguments about their being coerced fail simply because their assumption of 'disastrous consequences' is false.

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[4] Memo to legislators, 11/16/09 – from various organizations.

Also like her sister states, Michigan has applied often for waivers to provide more services or to cover more people. All waivers are supposed to meet a 'cost neutrality' test. So the nine waivers Michigan has in place or pending provide more service for the same cost. This is one of the underpinnings of the Medicaid expansion under the ACA, as well. More coverage for primary care should result in less costly treatment for most recipients and less cost shifting to the population that is covered by private insurance.

The Michigan waivers are:

> In December of 2005 the EPIC program was approved. This program supplies pharmaceutical services to senior citizens. This waiver was replaced by Part D of Medicare.
>
> An adult benefit waiver program was approved in 2004. It provides limited outpatient, ambulatory services to non-pregnant and childless adults between the ages of 18 and 64 who have a very low income. It will expire in September of 2014. People in this program will be covered by Medicaid in 2014 under the ACA.

In March 2006 the Michigan Plan First waiver was approved. It provides family planning advice to women, ages 19 to 44, at or below 185% of the FPL. (Note that this is higher than the ACA expansion of 133% FPL.) This waiver was to expire on December 31, 2011 Due to an option available under the ACA this program is still in place.

One waiver that did expire in 2009 was the Michigan Specialty Services and Supports waiver which was approved in 1998. That plan provided substance abuse and mental health services to adults.

The Michigan Choice plan, which provides support to keep the disabled in their homes, was approved in 1992 and will not expire until the Fall of 2012. It is designed to keep those over 65 years old, with no maximum age, and the disabled between 18 and 64, in their homes with chore services and other supports. This waiver is popular and saves the state money it would have had to spend on nursing home care on this population.

The Michigan waiver for children with mental disabilities was approved in 2005; implemented in 2008; and will not expire until 2013. It provides in-home services for children 0 to 19 years old who are mentally ill and for their caregivers.

> Another children's waiver program approved in 1983 and not scheduled to end until 2013 also provides supports for mentally ill and developmentally disabled children who are 0 to 17 years old.
> In 1987 the Michigan Habilitation Supports waiver was granted and it is not scheduled to expire until 2015. It provides outside the home, non-vocational services to people with developmental disabilities from the age of 0 until death.
>
> A ninth waiver program is under review but was requested first in 1996. It is called the Michigan Comprehensive Health Care Program.[5]

Every state has also chosen to provide pharmaceutical coverage, a non-mandatory service under the Medicaid Act.

Michigan's waivers are typical – attempts to stretch the Medicaid program to cover more people with basic care and often to keep people out of more intense and expensive care settings. The same policy is an underpinning of the Medicaid expansion at issue herein.

Far from opting out, Michigan has attempted to increase its coverage.

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[5] Information at Medicaid.gov website on "Waivers" pages.

In 2006, then Gov. Jennifer Granholm proposed a waiver that would have provided health benefits under Medicaid for another 550,000 residents of Michigan.

> In her State of the State address last month, Governor Jennifer Granholm proposed a new health insurance program called the "Michigan First Healthcare Plan". The proposal would provide health insurance coverage to uninsured adults under 200% of the poverty level by using $1.0 billion in Federal funds to cover an estimated 550,000 individuals.
>
> The Michigan First Healthcare Plan was included in the Governor's fiscal year (FY) 2006-07 Department of Community Health (DCH) budget, with a starting date of April 1, 2007. Partial-year funding of $200.0 million, all Federal, was proposed in the Executive budget.
>
> ……
>
> There is one issue that is key to any waiver request: Over the five-year life of a waiver, the waiver must be cost neutral to the Federal government.
>
> This sort of situation has come up before in Michigan–for instance, during the discussions of the managed care waiver 10 years ago, the Federal government approved the waiver because it was shown that there

should not be a Federal cost increase. The Engler Administration showed trend lines of expenditures if the system remained on a fee-for-service basis, then compared those to the projected costs of a managed care system, and demonstrated the likelihood of Federal savings.

In the case of managed care, there was a two-fold savings–overall Gross expenditures were projected to be lower than they would be otherwise, so both the Federal government and the State saved money. With the Administration's proposal, Federal expenditures would increase by about $1.0 billion per year. So the question arises: How can the Administration claim that this proposal would be cost-neutral to the Federal government?

The Administration indicates that it will start with a base year, then project future Medicaid expenditures if current trends continue. Its belief is that more and more people with employer-paid health insurance have been and will continue to be forced onto the Medicaid rolls, thereby increasing Federal costs over time, a trend that the Administration's proposal seeks to reverse.

......

Michigan's argument will be that the State has saved the Federal government over $2.0 billion over the last nine years due to the shift to managed care. The Administration

> will argue that the trend line expenditures, when started from the correct baseline and assuming there had been no shift to managed care but continued shifts of people from employer-paid health insurance to Medicaid, would show Federal Michigan Medicaid costs in the near future of at least $1.0 billion per year more than there would be under the Administration's proposal.[6,7]

This proposal goes beyond the ACA expansion by 67% of the Federal Poverty Level [FPL]. Gov. Granholm did not see it as coercive. She asked the federal government to provide even more coverage for more people than the ACA provides as of 2014.

This waiver would have been wise were it granted because more and more people are relying on Medicaid as their health insurer. Besides the Aged, Blind and Disabled which went from 121,314 covered in 2000 to 191,464 in 2009; the number of families, pregnant women, and other children under 21 rose from 531,571 people to 1,051,874. Families and non-disabled people are increasingly relying on Medicaid.[8]

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[6] "Governor Granholm's Michigan First Healthcare Plan"; By Steve Angelotti, Fiscal Analyst and David Fosdick, Fiscal Analyst; January/February 2006.

[7] See also Governor Granholm and HHS Secretary Leavitt Discuss Ways to Improve Access to Affordable Health Coverage, HHS Press release, January 29, 2007.

[8] *Déjà vu; Michigan Struggles to Fund Medicaid Program*; Michigan League for Human Services; May, 2010.

This is especially true since the system of employer sponsored coverage is fading, particularly in Michigan.

	Pop	Uninsured	MA Eligible	Employer
1995	9,543,462	8.1%	12.4%	74.4%
2000	9,956,111	10.1%	10.7%	69.0%
2005	10,120,860	11.0%	14.0%	60.0%[9]

The drop from almost 75% employer sponsored coverage to 60% in the decade from 1995 to 2005 has continued. 52% of Michigan residents currently have employer sponsored coverage.[10]

As one commentator writes:

> In a report released by the Economic Policy Institute in November 2010, **Michigan ranked No. 1** in the number of people, **nearly 1 million, who lost employer coverage** over the period 2000-01 to 2008-09.
> During this period, Michigan's Medicaid caseload grew from 1.1 million persons to nearly 1.7 million persons. It is important to note that during this period of dramatic job loss accompanied by the loss of employer-

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[9] Michigan League for Human Services, ; *Medicaid; The Facts*, 2007.

[10] Kaiser Family Foundation website.; www.state healthfacts. org.

> sponsored coverage, Michigan did not increase its Medicaid eligibility standards, and continues to have one of lowest income levels of our neighboring states to qualify. For a single parent, Michigan's eligibility limit, at just under 50 percent of the Federal Poverty Level ($5,418 annually for an individual), is more than two times lower than the next Great Lakes state, Ohio, which has an income limit of 100 percent of the Federal Poverty Level ($10,836 annually for an individual). Indiana covers adults with incomes up to 200 percent Federal Poverty Level. For adults without children, the income level to be eligible for the outpatient-only program is 35 percent of the Federal Poverty Level, or just under $3,800 annually.[11]

The employer sponsored insurance does not seem to be returning as the Michigan economy improves. Much of the lost coverage – from 74.4% in 1995 to 52% now occurred during better economic times.

This impacts the argument the states are making. States face tough choices but Medicaid will be expanding whether it is through a federal statute or the operation of the changing economy. Would the states really reject federal aid to help meet what is such a major economic change? Is this coercive, or a means by which we can demonstrate that we can work together as a nation to address a major economic change?

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[11] Understanding Medicaid Complex, Compassionate, Cost Effective; October 2011; Jan Hudson, MLHS.

Today children and their parents make up 74% of the Medicaid population in Michigan, reflecting this changing method of providing health insurance coverage.

> It is striking to note that it is not Michigan's poorest counties that have experienced the highest rates of growth. Livingston County has experienced the largest rate of increase in Medicaid eligibility over the period June 2002–June 2010, with a rate of 191 percent. In other words, the Medicaid caseload in that county has nearly tripled. During that same period, Livingston County's unemployment rate increased from 3.1 percent to 11.8 percent. Macomb County, the county with the next highest rate of Medicaid caseload increase at 146 percent, experienced an increase in their unemployment rate from 7.3 percent to 14.4 percent. Other counties where Medicaid caseloads have more than doubled during this period include: Ottawa, Lapeer, Grand Traverse and Oakland.
>
> The Affordable Care Act requires that states maintain their Medicaid eligibility at the level in place on March 23, 2010. All Republican governors, except Michigan Gov. Rick Snyder, have written to Congress requesting relief from that requirement. It is

> laudable that Governor Snyder is maintaining his priority that "every citizen has access to affordable, quality health care" even in tough economic times.
>
> In FY2010, the Medicaid program paid for 51 **percent of the births** in Michigan, up from 35 percent in FY2003. During this period, Michigan's Medicaid income eligibility for pregnant women has remained constant at 185 percent FPL ($33,900 for a family of 3).
>
> .....
>
> **The general public understands the importance of the Medicaid program as is repeatedly demonstrated in polling by Kaiser Family Foundation** "The generally positive feeling about the program among those who have experienced it may explain why the poll also finds that 60 percent of people want to keep Medicaid as it is."[12]

Attached as an Appendix is a chart[13] showing the optional and mandatory services covered by Michigan Medicaid and the percentage of the

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[12] Understanding Medicaid Complex, Compassionate, Cost Effective; October 2011; Jan Hudson, MLHS – emphasis in original.

[13] Understanding Medicaid Complex, Compassionate, Cost Effective; October 2011; Jan Hudson, MLHS.

Federal Poverty Level that qualifies a person for the benefit. The significant differences in FPL qualifying levels also undercuts Petitioners' argument that the ACA is coercive.

But perhaps even more damaging to the states' argument about coercion is the broad array of eligibility criteria to qualify for Medicaid in other states. Each state has set its own criteria. All are listed at the Georgetown Center Health Policy Institute on "Eligibility Levels in Medicaid & CHIP for Children, Pregnant Women, Parents, and Childless Adults." For parents, for example, the range of eligible incomes between states goes from 29% to 215%. This shows significant 'free will' in the Medicaid program.

Legal Argument:

In the *State of Florida* decision the court analyzes the coercion doctrine from its beginnings in *Charles C. Steward Machine Co. v. Davis,* 301 U.S. 548, 57 S.Ct. 883 (1937). There a corporation challenged the imposition of an employment tax under the newly enacted Social Security Act. Because every tax and regulation is to some degree coercive,

> . . . to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties. The outcome of such a doctrine is the acceptance of a philosophical determinism by which choice becomes impossible. Till now the law has been guided by a robust common sense which assumes

> the freedom of the will as a working hypothesis in the solution of its problems.... Nothing in the case suggests the exertion of a power akin to undue influence, if we assume that such a concept can ever be applied with fitness to the relations between state and nation. Even on that assumption the location of the point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree, at times, perhaps, of fact.

Charles C. Steward Machine Co. v. Davis, 301 U.S. at 589–90, 57 S.Ct. at 892.

In *South Dakota v. Dole* the state of South Dakota challenged 23 U.S.C. § 158, which directed the Secretary of Transportation to withhold a percentage of federal highway funds otherwise allocable to a states if that state failed to maintain a minimum drinking-age requirement of 21 years. 483 U.S. at 205, 107 S.Ct. at 2795. The Court noted that Congress may attach conditions on the receipt of federal funds to meet certain policy objectives, including those that Congress could not otherwise meet through direct regulation. *Id.* at 206–07, 107 S.Ct. at 2795–96.

As the *State of Florida* court observed;

> The limited case law on the doctrine of coercion and the fact that the Supreme Court has never devised a test to apply it has left many circuits with the conclusion that the

doctrine, twice recognized by the Supreme Court, is not a viable defense to Spending Clause legislation. *See, e.g., Pace v. Bogalusa City Sch. Bd.*, 403 F.3d 272, 278 (5th Cir. 2005) (en banc) ("It goes without saying that, because states have the independent power to lay and collect taxes, they retain the ability to avoid the imposition of unwanted federal regulation simply by rejecting federal funds."); *A.W. v. Jersey City Pub. Schs.*, 341 F.3d 234, 243–44 (3d Cir. 2003) (noting that the state's freedom to tax makes it difficult to find a federal law coercive, even when that law threatens to withhold all federal funding in a particular area); *Kansas v. United States*, 214 F.3d 1196, 1201–02 (10th Cir. 2000) ("The cursory statements in *Steward Machine* and *Dole* mark the extent of the Supreme Court's discussion of a coercion theory. The Court has never employed the theory to invalidate a funding condition, and federal courts have been similarly reluctant to use it." (footnote omitted)); *id.* at 1202 (observing that the theory is "unclear, suspect, and has little precedent to support its application"); *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997) (noting in a Medicaid expansion case that "to the extent that there is any viability left in the coercion theory, it is not reflected in the facts of this record"); *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989) ("The difficulty if not the impropriety of making judicial judgments regarding a state's financial

capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and state governments."); *Oklahoma v. Schweiker,* 655 F.2d 401, 414 (D.C.Cir. 1981) ("The courts are not suited to evaluating whether the states are faced here with an offer they cannot refuse or merely a hard choice.... We therefore follow the lead of other courts that have explicitly declined to enter this thicket when similar funding conditions have been at issue.") (pre-*Dole*); *N.H. Dep't of Emp't Sec. v. Marshall,* 616 F.2d 240, 246 (1st Cir. 1980) ("Petitioners argue, however, that this option of the state to refuse to participate in the program is illusory, since the severe financial consequences that would follow such refusal negate any real choice.... We do not agree that the carrot has become a club because rewards for conforming have increased. It is not the size of the stakes that controls, but the rules of the game.")
(pre-*Dole*).

Even in those circuits that do recognize the coercion doctrine, it has had little success. *See West Virginia v. HHS,* 289 F.3d at 290, 294–95 (rejecting a coercion doctrine challenge to previous Medicaid Act amendments on the ground that the Secretary may choose to withhold only some funds); *Jim C. v. United States,* 235 F.3d 1079, 1081–82 (8th Cir. 2000) (en banc) (holding that loss of all federal education

> funds, in that case amounting to 12% of the state's education budget, was "politically painful" but not coercive). Indeed, our review of the relevant case law indicates that no court has ever struck down a law such as this one as unduly coercive.

State of Florida, pp. 1265 – 6.

The Court goes on to rule:

> For now, we find it a reasonable conclusion that *Dole* instructs that the Tenth Amendment places certain limitations on congressional spending; namely, that Congress cannot place restrictions so burdensome and threaten the loss of funds so great and important to the state's integral function as a state—funds that the state has come to rely on heavily as part of its everyday service to its citizens—as to compel the state to participate in the "optional" legislation. This is the point where 'pressure turns into compulsion.' *Dole,* 483 U.S. at 211, 107 S.Ct. at 2798 (quoting *Steward Mach.*, 301 U.S. at 590, 57 S.Ct. at 892).

State of Florida at p. 1267.
The court's analysis is sound. The ACA is complex legislation over a very complex industry. There are numerous opportunities for states to create savings in their Medicaid programs to pay for the small amount the state will be required to contribute. In some states the contribution will be minimal because

those states have historically exercised their 'free will' in favor of health coverage for their residents. Other states may have to invest more because they chose, over the history of the Medicaid program, to provide less to their citizens.

It is not coercive now if a state in the past has exercised its 'free will' in the past to the detriment of health care for its residents. These past exercises of free will under the Medicaid program are the reason that some states will face more costs than others. This past behavior, deciding not to provide coverage, cannot be a factor in the determination of whether the ACA Medicaid expansion is coercive today. And yet it is clear that the more the cost of the Medicaid expansion, the more the 'coercion' seems to exist. But if a state made bad choices in the past which will cost them more now to participate in the expansion that is not the same as being 'coerced' now.

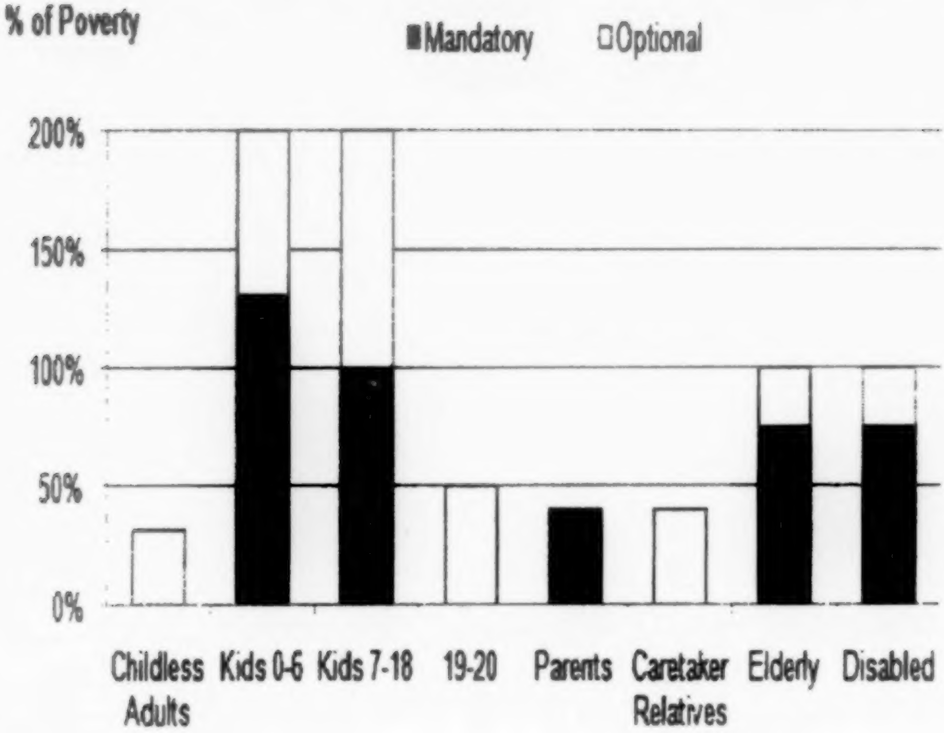
CONCLUSION

For the reasons set forth in this brief *Amici* request that the court affirm the decision of the Eleventh Circuit, and all other courts that have faced this issue, and find that the Medicaid expansion under the ACA is constitutional.

Michigan Legal Services, Inc.
By: Gary A. Benjamin, Esq. (P29103)
220 Bagley, Suite 900
Detroit, MI 48226
313-590-6136
gbenjamin@michiganlegal.org

DATED: February 17, 2012

Appendix


% of Poverty
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Childless Adults
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19-20
Parents
Caretaker Relatives
Elderly
Disabled

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

In the Supreme Court of the United States

National Federation of Independent
Businesses, *et al.*,
Petitioners,
v.

Kathleen Sibelius, Secretary of Health
and Human Services, *et al.*,
Repondents.

States of Florida, *et al.*,
Petitioners,
v.

Department of Health and Human
Services, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of
Appeals for the Eleventh Circuit

Amicus Brief of Michigan Legal Services, Inc. and other Michigan Non-profit Corporations in Support of Government's Position on Severability

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MICHIGAN LEGAL SERVICES, INC.
GARY A. BENJAMIN, ESQ. (P 29103)
Counsel for *Amici*
220 Bagley; Suite 900
Detroit, MI 48226
Tel: (313) 590-6136
gbenjamin@michiganlegal.org.

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Introduction and Dedication

The Patient Protection and Affordable care Act [ACA hereinafter] expanded health care coverage in several ways by reforming the health care financing and delivery system. These reforms benefit all of us.

Amici have attempted to put the ACA in context. The so-called 'mandate' is only one tool, and not the most important one, in the ACA. The ACA has already taken effect in major ways, with one of its most basic provisions already implemented [Medical Loss Ratio limits].

Our present system burdens ordinary Americans and does not deliver services to millions who need them. Bankruptcy, medical debt, and morbidity and mortality all increase in the system as it is now. If there is a 'liberty' interest here it is in those who will be free of the burdens the present system imposes and who will be able to live fuller lives, living up to their full potential, because of the ACA.

We dedicate this brief to those who have suffered under the present system – especially to the thousands who have died because they had no insurance and no access to affordable care.[1]

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[1] All parties have consented to this *Amicus curiae* brief and letters of consent have been filed with the Clerk. Pursuant to Rule 37.6, *Amicus* represents that no counsel for a party authored this brief in whole or in part, and no person or entity other than *Amicus* and its counsel made a monetary contribution to the preparation or submission of this brief.

Statements of Interest

Michigan Legal Services has represented persons at or below 200% of the Federal Poverty Level for over thirty years. The Affordable Care Act [ACA] significantly increases access to health insurance and health care to that population through many provisions of the ACA. We argue that people need to be free from the present business model so that we can all live full and productive lives. The ACA, with or without the 'mandate' will allow more Americans to live such lives.

People with higher incomes also are significantly impacted by the cost of insurance on the individual market. MichUHCAN [Michigan Universal Health Care Access Network, Inc.] has been an advocate for people at all income levels. MichUHCAN is a grass roots organization with members throughout the State.

Michigan Consumers for Healthcare represents more than 110 community and healthcare advocacy organizations, and works collaboratively with a diverse alliance of consumers, partners, and policymakers to attain affordable, accessible, quality healthcare for everyone in Michigan through education, outreach, advocacy and stakeholder engagement. MCH recognizes the Affordable Care Act (ACA) as the nation's most comprehensive healthcare reform effort in our history, presenting our best opportunity to make the vision of affordable, robust, and universal healthcare coverage a reality. ACA is a historic turning point in American healthcare, and its survival and implementation are crucial for the protection and advancement of consumer health.

The Center for Civil Justice is a non-profit law firm that advocates for low-income people in mid-Michigan who face challenges accessing basic human needs and services, including health care. In the area of health care, the Center's clients are uninsured or underinsured, low-income individuals and families who face difficulty qualifying for, or benefiting from, governmental healthcare programs like Medicaid and Medicare. In addition to direct legal representation of low income individuals and families, the Center works closely with private, non-profit human services providers throughout mid-Michigan that attempt to fill the gaps when low income individuals are uninsured or lack the health care coverage that they need to access necessary medical care. The Center receives a local grant to provide intensive advocacy and increase access to governmental health insurance programs for low income clients in Genesee County (Flint) Michigan.

The 'severability' issue affects more people represented by these organizations than does the 'mandate.'

For example – BL had a heart valve repair with a valve replacement. The after care did not go as planned and the valve leaked and caused pain, anemia and angina. Further surgeries occurred and now BL must take an anti-rejection medication that costs over $3,000 a month. She gets a pension and has been able to maintain health insurance with a premium of over $2,000 a month through Blue Cross, Michigan's 'insurer of last resort. After she pays the premium she has no money left for basic needs and is dependent on relatives.

Michigan's system with an 'insurer of last resort' has worked for years, but the high cost of care for those with pre-existing conditions has made that system less viable for consumers.

BL is awaiting 2014 when she can get health insurance coverage without regard to her pre-existing condition through an exchange the same rate at which healthy people her age are insured – less than $500 a month.

MLS, MichUHCAN, the Center for Civil Justice and MCHA come across dozens of people every month who are at or below 138% of the Poverty Level who would become eligible for Medicaid. The ACA would benefit almost everyone these organizations represent. That is our interest in the 'severability' issue. The public focus on the mandate is out of proportion to both what the 'mandate' really says, and to its effect on the ACA.

Amici will try not to re-hash the case law as the Court will receive many briefs regarding precedents. This brief will not re-hash most of the statistical data for the same reason.

Summary of Argument

The 'mandate' should be severed because several sections of the ACA are already in effect and are clearly meant to 'stand alone.' Other portions have to do with changing the delivery system for health care which the mandate does not affect. The ACA contains many 'moving parts' designed to correct a myriad of problems with our health care financing and delivery systems and, in fact, the Medicaid expansion provides coverage to more people than the mandate does.

The ACA is designed so that some parts of the Act do support others, but none of these 'moving parts' are so important that the failure of one or two should result in the entire ACA being declared unconstitutional. The two provisions that are most connected to the mandate – pre-existing condition exclusions being prohibited and guaranteed issue and re-issue – are stand alone sections in several states. It is not 'evident' that without the mandate Congress would not have enacted the insurance reforms.

We all have a 'liberty interest' in maintaining the rights granted under the ACA. Americans have the right to live a full life with the opportunity to fully develop their talents. The ACA enhances and protects that right to life, liberty, and the pursuit of happiness.

Argument: The Patient Protection and Affordable Care Act's Individual Responsibility Section is Not so Important to the Other Provisions of the ACA that if it is Declared a Violation of the Constitution's Commerce Clause, it Should be Severed from the Rest of the PPACA.

Background

Much of the history of health insurance; health care delivery; and efforts at reform are undisputed and will appear in many briefs. Even analyses of problems with the present system are, in large part, agreed upon by all parties.

In the last Presidential election both candidates argued that the present model of providing health insurance must change. Insurance companies, to remain solvent, deny coverage to people with pre-existing conditions; rescind coverage when people became ill, and therefore expensive to care for; place 'caps' on coverage to make more predictable their obligations under their insurance agreements with individuals and groups; and engage in other behaviors that undercut the insurance model. While Sen. McCain focused on costs and inflation as problems; then-Sen. Obama focused on access to coverage and care.[2]

---

[2] Sen. McCain did present proposals to increase the number of walk-in clinics and to use FQHC's and high-risk pools to cover the hard to insure.
http://www.issues2000.org/Celeb/John_McCain_Health_Care.htm

In order to remain financially viable health insurance companies now 'cut their losses' by not paying for health care for the most ill people they insure. This problem especially affects the individual and small group markets.

Insurers argued, in the legislative process, that if the government denied them the right to engage in these financially driven behaviors, they needed a larger pool of people to buy insurance – a pool that included people who would not be using health care services.

If a company insures 100 people at $100 a year they have $10,000 to spend on health care. If one of their 100 people is diagnosed with cancer all that money will be quickly used up and the company will suffer a loss. So, in defense of their bottom line, the company has these choices –

> Drop coverage of the cancer victim; or
>
> Increase premiums for everyone
> to cover the necessary care; or
>
> Find more people who are healthy to
> add to the pool, for example another
> group of 100 bringing in another
> $10,000; or
>
> Some combination of the above choices.

Administratively the first option is the easiest and the one that most surely will cut the "Medical Loss Ratio" [MLR][3].

The ACA is the government's response to this business model.

History of Health Insurance

The United States has a unique system of health insurance. It was developed at Baylor Hospital by a provider who realized that it could have a more secure cash flow if it got paid through a system of pre-paid insurance. The group policy was born.[4]

Today, these policies are often offered by large employers. At one point around 65% of Americans were insured through group policies through this Employer Sponsored Insurance [ESI]. From the beginning of our health insurance system employers and providers were the driving forces. Health care and health care finance are closely intertwined.

Today slightly less than 50% of the population has ESI. Cost of coverage has become prohibitive. Those that do have ESI are often employed by larger employers that self-insure. These large groups usually do not engage in the behaviors that the ACA changes – rescission; denying policies for preexisting conditions; etc. – because their groups are so large they can increase premiums more easily or can add healthy people. Generally large employers behave in the way the ACA requires all insurers to behave.

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[3] MLR is the rate at which premium dollars are paid out to medical care providers. A low MLR means the company is not spending as much of the premium dollars on its insured lives as a higher MLR would indicate.

[4] Cohn, Jonathan; *Sick*; Harper-Collins (2007); pp. 7-10.

Large employers also may encourage their employees to engage in healthy behaviors – smoking cessation; exercise; weight loss are all common programs. Wellness plans are designed to make those who are insured healthier. Healthier people equals less expensive care.

Large groups can also contract with providers to pay lower fees. Often uninsured people are billed at rates 2 to 3 times higher than large insurers, or Medicare or Medicaid.

But there is a market for people who have no group – the individual market – and a market for smaller businesses – the 'small group' market. Neither of these markets have the same ability to control medical fees or to encourage the people they insure to engage in healthy behavior. In these markets the ability to cut losses means denying people the benefits for which they contracted or denying them coverage in the first instance for a pre-existing condition - the very condition for which they need care. Their pools were smaller and their premiums higher.

Government Already Covers the Highest Risk Populations

In 1964 Medicare and Medicaid were enacted. Medicare cares for the elderly and the disabled. Medicaid cares for some of the poor and for poor women and their children and for another group of disabled [SSI recipients]. Later the Childrens' Health Insurance Program (CHIP) was enacted with bi-partisan support.

The government makes sure children, the disabled, and the elderly have health coverage and, as a result, access to health care. The middle segment of the population – between 18 and 65 – are left to fend for themselves, unless they are disabled. It is this coverage scheme that the ACA attempts to adjust through private market reforms.

49% of Americans have ESI. Medicaid covers 17% of the population and Medicare 12%. Private, individual coverage is 5% and uninsured 16%. [5] The mandate would not apply to 78% of the population – those with ESI, Medicare or Medicaid. Those who have individual coverage may also be exempt. Many of the uninsured will either receive Medicaid, or remain uninsured. The mandate affects a relatively small slice of the population especially when the exceptions and exemptions in the ACA relieves millions of the duty to buy coverage or pay the penalty.

---

[5] Kaiser Family Foundation - http://facts.kff.org/chart.aspx?ch=477

The government response, in the past, has been to insure through public programs the aged; the disabled; and children. Even that is in danger because of the cost of care. So the ACA was enacted and its Exchanges and other reforms are designed to be able to act to control medical inflation, as well as cover more people. Without the extra coverage, particularly of healthy people, there is less market influence by insurers and less ability to control costs. Without the added coverage there is also less ability to create incentives for 'wellness' programs.

Liberty Interest Protected by the ACA

This system covers favored populations and leaves others without insurance; and without affordable access to primary or preventive care. It is true that emergency departments must provide stabilizing care, but that does not provide care for chronic disease that would keep the individual out of the hospital. This is high cost care, when lower cost, primary care would be better for the patient, and would free the patient as much as possible f rom the effects of disease allowing them to live a fuller, more productive life.

For example, C has diabetes; works part time in a cafeteria; makes too much to qualify for Medicaid; is not 'disabled'; and cannot find affordable coverage. As a result she is in the ER once or twice a year; given care to stabilize her condition and released. Having no access to a doctor the cycle repeats itself resulting in high hospital bills when basic treatment would keep her healthier.

The present system also forces people like C into bankruptcy when they get needed care and cannot afford to pay for it. So some provisions of the ACA focus on hospital's 'charity care.' The present system does not provide enough primary care or prevention or wellness. The ACA addresses that problem, too.

The present system locks people in to jobs because of their coverage. B had a heart condition and was covered by her employer's insurance. She was offered another job at higher pay but could not take it because there was a 6-month pre-existing condition waiting period. The ACA addresses that problem through the insurance reforms as well as creating an Exchange. B's freedom in the job market was constrained by her health insurance.

While the Appellants argue that the Congress does not have the power under the Commerce Clause to create the 'mandate,' it appears that they are really complaining about their freedom to avoid their own responsibility. They argue that they should not be required to buy something they do not want even though their failure to contribute to the system means that millions of their fellow Americans remain uninsured. Personal responsibility means finding coverage for yourself and your family; not avoiding coverage and throwing the financial burden of your care onto others.

Abraham Lincoln said,

> We all declare for liberty; but in using the same word we do not all mean the same thing. With some the word liberty may mean for each man to do as he pleases with himself, and the product of his labor; while with others, the same word may mean for some men to do as they please with other men, and the product of other men's labor. Here are two, not only different, but incompatible things, called by the same name - liberty. And it follows that each of the things is, by the respective parties, called by two different and incompatible names - liberty and tyranny.[6]

In the health care debate there is a similar conflict. The 'liberty' of a healthy individual to opt out of the insurance market means that those who purchase insurance pay for their care. This drives the price of premiums up. Higher premiums mean more people who *would* buy insurance, cannot afford to. The cost of their care is also thrown on to the diminishing number who have insurance, spiraling premiums upward yet again. The liberty of others to buy coverage is limited by the liberty exercised by some to avoid buying insurance.

---

[6] *The Collected Works of Abraham Lincoln* edited by Roy P. Basler, Volume VII, "Address at Sanitary Fair, Baltimore, Maryland" (April 18, 1864), p. 301-302.

This trend, coupled with the fact that health care costs are rising for other reasons, leads to higher and higher premiums; more and more un-insurance; and more people on government insurance and off of private coverage.

Our Declaration of Independence says "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.--That to secure these rights, Governments are instituted among Men. . ." The Preamble to the Constitution makes it clear that the role of government includes the promotion of the "general welfare."

The ACA frees Americans from the insurance model that is now failing to provide health care to significant segments of the population. Because that insurance model has become so fragmented the ACA has 'attacked' it with many tools. These tools could all stand alone.

Those tools are instruments of liberty for our clients, freeing BL, C, and B from the access to care problems they face.

Sections of ACA Already in Effect

Several provisions are already in effect. These provisions cannot be tied to the mandate since the mandate is not in effect until 2014. For example the requirement that each health insurer spend at least 80% of the premium dollars on actual health care

[85% for larger employers] is already in effect. No one is challenging its Constitutionality. Some commentators believe this is the most important provision in the ACA.[7] It is clearly not connected to the mandate.

Other provisions already in place include;

> Insurers can no longer deny children coverage because of a pre-existing condition;
>
> Individuals who meet certain criteria can purchase insurance from a 'pre-existing insurance plan' set up by the ACA and presently covering about 45,000 people;[8]
>
> Adult children can remain on their parent's group policy which has resulted in covering 2.5 million young adults;[9]
>
> Insurers who request premium increases now must, if the increase is 10% or more, post it

---

[7] Others suggest that the Exchange or the Medicaid expansion are the most important.

[8] Announced by HHS at Herndon Alliance Annual meeting; January 21, 2012. This plan would not help BL because she would have to be uninsured for 6 months; a chance she cannot take.

[9] Announced by HHS at Herndon Alliance Annual meeting; January 21, 2012.

online and subject the increase request to public comment;[10]

Lifetime caps for health insurance are illegal;

Annual caps have been raised and made the subject of federal regulation;

Medicaid across the country was preserved last year because of the 'maintenance of effort' clause of the ACA;

Insurers can no longer charge co-pays for a wide range of preventive procedures resulting in greater use of those procedures and earlier detection of disease;[11]

Companies with early retirees who would lose their coverage have been provided subsidies to maintain the insurance for those early retirees, who are often being 'forced out' due to the economy;

Medicare recipients have seen Part D improved so that the 'doughnut hole' is closing and will be completely closed as of 2020 ;[12]

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[10] Five such requests are posted for Michigan as of early January, 2012. some insurers in other states have lowered their requests as a result of this provision.

[11] 30 million Medicare recipients benefited from this provision already. Announced at Herndon Alliance; January 21, 2012.

[12] 3 million Medicare recipients have benefited. HHS at Herndon; January 21, 2012.

Funds have been granted to expand the medical education system and graduate more primary care providers;

Planning for Exchanges has occurred in many states, including Michigan where SB 693 has passed the Senate and is awaiting action in the House;

Accountable Care Organizations and Medical or Health Homes are encouraged by the ACA and planning has begun to implement these provisions creating changes in the delivery of care;

Insurers can no longer rescind a policy due to the need for care;

Insurance documents have to be written in consumer friendly language;

Insurers must have an internal appeals process for denials.

These are all significant reforms affecting the daily lives of Michiganders. These reforms have the effect of increasing the pool; controlling premiums; transforming the delivery of care to focus more on primary or preventive care; increasing the number of providers; and protecting consumers.

None of these provisions depend upon the implementation of the mandate.

Indeed three provisions of the ACA have been substantially changed or totally abandoned. The number of FQHC's contemplated under the ACA was significantly reduced because of costs. The CLASS system – long term care insurance – was abandoned because the administration determined the program was not fiscally sound in the long term. A requirement of IRS reporting for small businesses was repealed.

The whole ACA did not fall apart because of the failure of these provisions even though they were important to the passage of the Act. FQHC's care for the uninsured and provide them a medical home – lowering the cost of that care. CLASS would have provided resources to care for high-cost people with severe disabilities in the future. And the small business reporting would have provided some funding.

Proportion vs. Political Hyperbole

The mandate was correctly described by the Eleventh Circuit when it found the mandate is not such a crucial part of the ACA as to require any of the ACA to be struck down with the mandate. Indeed, Medicaid expansion; the Exchanges; and MLR reforms are probably the most important parts of the ACA.

District Court Analysis was Flawed

The District Court found that an analysis of Congressional intent was needed. That Court analogized the ACA to a 'finely crafted watch' which, absent the mandate, would not operate as 'Congress intended.' *Florida et al. v. Kathleen Sibelius, et al.*, 780 F. Supp. 2d 1256, 1304 (N.D. Fla. 2011).

Yet three other provisions have already been dropped. Perhaps the watch was not so finely crafted after all. The court writes, "Although many of the remaining provisions, as just noted, can most likely function independently of the individual mandate, there is nothing to indicate that they can do so in the manner intended by Congress."
Florida et al. v. Kathleen Sibelius, et al., 780 F. Supp. 2d 1256, 1304 (ND Fla, January 31,2011)

This constricted analysis was rightly rejected by the 11th Circuit. After all, there are 535 Members of Congress. Determining how even a single member felt the ACA would function, or how a particular provision would function, at the time of voting on the ACA, is the sort of mind reading that courts avoid.

The fact is that many of the provisions of the ACA can clearly function independently. To assume that Members of Congress did not realize that is erroneous.

The District Court went on to point out that the Government had acknowledged that the Mandate was crucial to and connected with the insurance reforms. Indeed, this connection is included in the ACA itself.

> [I]f there were no [individual mandate], many individuals would wait to purchase health insurance until they needed care . . . The [individual mandate] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

Act § 1501(a)(2)(I)

As an *Amicus* we do not accept the Government's throwing insurance reform under the mandate 'bus.' Section 1502(a)(2)(I) makes it clear that the mandate attempts to insure that people do not wait to purchase coverage until they are ill. The mandate is not the only way to accomplish this and Congress knew that at the time. Congress also rejected the 'public option' as a way to encourage purchasing coverage. Since the mandate can be replaced, it is 'evident' that the mandate can be severed.

The test for severability is:

> First, we try not to nullify more of a legislature's work than is necessary, for we know that a ruling of unconstitutionality frustrates the intent of the elected representatives of the people. . . . Second, mindful that our constitutional mandate and

> institutional competence are limited, we restrain ourselves from rewriting [a] law to conform it to constitutional requirements even as we strive to salvage it . . . Third, the touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature.

Ayotte v. Planned Parenthood of Northern New England, 546 U.S. 321, 329-30, 126 S. Ct. 961, 163 L. Ed. 2d 812 (2006)

The 'finely crafted watch' analogy is absent from this test. Perhaps courts realize that to expect any collective body to create a 'finely crafted' instrument is unrealistic.

The court writes in conclusion:

> In sum, notwithstanding the fact that many of the provisions in the Act can stand independently without the individual mandate (as a technical and practical matter), it is reasonably "evident," as I have discussed above, that the individual mandate was an essential and indispensable part of the health reform efforts, and that Congress did not believe other parts of the Act could (or it would want them to) survive independently. I must conclude that the individual mandate

> and the remaining provisions are all inextricably bound together in purpose and must stand or fall as a single unit. The individual mandate cannot be severed.

Florida et al. v. Kathleen Sibelius, et al., 780 F. Supp. 2d 1256, 1305 (N.D. Fla. 2011).

In fact Congress did not intend the whole ACA to depend on the mandate. Else it would have said so in § 1501(a)(2)(I). Instead Congress explicitly limits the mandate to being 'essential' only to the insurance reforms. The court has to pile an inference on its ruling saying that the 'insurance reforms' are essential to the rest of the ACA when there is absolutely no indication from Congress to that effect.

In fact, the mandate is not 'essential' to the insurance reforms. It is simply one tool that Congress chose. In fact, as Judge Vinson acknowledged;

> . . . it should be emphasized that while the individual mandate was clearly "necessary and essential" to the Act as drafted, it is not "necessary and essential" to health care reform in general. It is undisputed that there are various other (Constitutional) ways to accomplish what Congress wanted to do.

Florida et al. v. Kathleen Sibelius, et al., 780 F. Supp. 2d 1256, 1305 at fn 30 (N.D. Fla. 2011)

A list of possibilities includes the way Medicare part B works, automatically enrolling people in coverage and allowing them to 'opt out' if they preferred not to buy the insurance. Medicare Part D operates with a voluntary enrollment but a penalty if the person delays enrolling. Other ideas are to conduct a public education and outreach campaign; provide broad access to personalized assistance for health coverage enrollment; impose a tax to pay for uncompensated care; condition the receipt of certain government services upon proof of health insurance coverage; use health insurance agents and brokers differently; or require or encourage credit rating agencies to use health insurance status as a factor in determining credit ratings. Combining one of these ideas with an Exchange has been raised as a possibility by Rep. Ryan and Sen. Wyden, among others. To assume Congress was unaware of alternatives disrespects the legislative process. Indeed, the mandate is not essential. It may have been the best possible alternative given the political 'log rolling', but it is not 'evident' that if it fails Congress would want the rest of the ACA to be struck down.

> Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law.

Alaska Airlines Inc v. Brock, 480 US 678, 684 (1987)

There is no constitutional challenge to any other part of the ACA, save Medicaid. The rest of the ACA is 'fully operative.' Severing the mandate may have a negative effect on premiums, but it does not negate the law.

Eleventh Circuit Analysis

In the 11th Circuit Judges Dubina and Hull rejected Judge Vinson's analysis. The court begins by noting that Congress found there were about 50 million uninsured people and $43 Billion in uncompensated care which leads to cost shifting.

> The findings state that this cost-shifting scenario increases family premiums on average by $1,000 per year. *Id.* § 18091(a)(2)(F). Although not in the findings, the data show the cost-shifting increases individual premiums on average by $368–410 per year. The cost-shifting represents roughly 8% of average premiums. In its findings, Congress also points out that national health care in 2009 was approximately $2.5 trillion, or 17.6% of the national economy.10 *Id.* § 18091(a)(2)(B).

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1244-5 (11th Cir. 2011)

The size of the health care sector in our economy argues that the mandate must be severed. Can anyone seriously argue that regulating and reforming a sector that is larger than most other nation's economies entirely depends on one section of one act?

The Eleventh Circuit also noted that Congress eliminated underwriting costs to the tune of $90 Billion because the ACA requires insurers to accept all applicants. The cost of the insurance reforms supposedly connected to the 'mandate' are adequately funded by these underwriting savings. 42 U.S.C. § 300gg-1(a).

> . . . the Act employs five main tools: (1) comprehensive insurance industry reforms which alter private insurers' underwriting practices, guarantee issuance of coverage, overhaul their health insurance products, and restrict their premium pricing structure; (2) creation of state-run "Health Benefit Exchanges" as new marketplaces through which individuals, families, and small employers, now pooled together, can competitively purchase the new insurance products and obtain federal tax credits and subsidies to do so; (3) a mandate that individuals must purchase and continuously maintain health insurance or pay annual penalties; (4) penalties on private employers who do not offer at least some type of health plan to their

> employees; and (5) the expansion of Medicaid eligibility and subsidies.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1246 (11th Cir. 2011)

The court goes on to note that most Americans already have insurance that satisfies the 'mandate.' ESI, Medicaid, and Medicare recipients all meet the criteria of the mandate. The court writes:

> The government's assertion that the individual mandate is "essential" to Congress's broader economic regulation is further undermined by components of the Act itself. In *Raich*, [*Gonzales v. Raich*, 545 U.S. 1, 22, 125 S. Ct. 2195, 162 L. Ed. 2d 1 (2005)] Congress devised a "closed regulatory system," *id.* at 13, 125 S. Ct. at 2203, designed to eliminate *all* interstate marijuana traffic. Here, by contrast, Congress itself carved out eight broad exemptions and exceptions to the individual mandate (and its penalty) that impair its scope and functionality. *See* 26 U.S.C. § 5000A(d)–(e). Even if the individual mandate remained intact, the "adverse selection" problem identified by Congress would persist not only with respect to these eight broad exemptions, but also with respect to *those healthy persons who choose to pay the mandate penalty*. Those who pay the penalty one year

> instead of purchasing insurance may still get sick the next year and *then* decide to purchase insurance, for which they could not be denied.
>
> Additionally, Congress has hamstrung its own efforts to ensure compliance with the mandate by opting for toothless enforcement mechanisms. Eschewing the IRS's traditional enforcement tools, the Act waives all criminal penalties for noncompliance and prevents the IRS from using liens or levies to collect the penalty. *Id.* § 5000A(g)(2). Thus, to the extent the uninsureds' ability to delay insurance purchases would leave a "gaping hole" in Congress's efforts to reform the insurance market, Congress has seen fit to bore the hole itself.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1311 (11th Cir. 2011)

We agree with the Eleventh Circuit's analysis.

> . . . the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1322 (11th Cir. 2011)

. . . .

> It is also telling that none of the insurance reforms, including even guaranteed issue and coverage of preexisting conditions, contain any cross reference to the individual mandate or make their implementation dependent on the mandate's continued existence. *See United States v. Booker*, 543 U.S. 220, 260,125 S. Ct. 738, 765 (2005) (stating that 18 U.S.C. § 3742(e) "contains critical cross-references to the (now-excised) § 3553(b)(1) and consequently must be severed and excised for similar reasons"); *Alaska Airlines*, 480 U.S. at 688–89, 107 S. Ct. at 1482 ("Congress did not link specifically the operation of the first-hire provisions to the issuance of regulations."). Indeed, § 300gg-3's prohibition on preexisting condition exclusions was implemented in 2010 with respect to enrollees under 19, despite the individual mandate not taking effect until 2014.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1324 (11th Cir. 2011)

. . . .

> "[T]he remedial question we must ask" is "which alternative adheres more closely to Congress' original objective" in passing the Act: (1) the Act without the individual mandate but otherwise

> intact; or (2) the Act without the individual mandate and also without these two insurance reforms. *See Booker*, 543 U.S. at 263, 125 S. Ct. at 766–67.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1324 (11th Cir. 2011)

If the mandate falls, the American public should not be denied insurance due to pre-existing conditions. The public should not be 'punished' for Congress's error. Congress did not intend for the insurance reforms to fail just because a particular part of the ACA falls.

The court went further with its analysis.

> First, the Act retains many other provisions that help to accomplish some of the same objectives as the individual mandate. *See Booker*, 543 U.S. at 264, 125 S. Ct. at 767 ("The system remaining after excision, while lacking the mandatory features that Congress enacted, retains other features that help to further these objectives."); *New York v. United States*, 505 U.S. at 186, 112 S. Ct. at 2434 ("Common sense suggests that where Congress has enacted a statutory scheme for an obvious purpose, and where Congress has included a series of provisions

operating as incentives to achieve that purpose, the invalidation of one of the incentives should not ordinarily cause Congress' overall intent to be frustrated."). For example, Congress included other provisions in the Act, apart from and independent of the individual mandate, that also serve to reduce the number of the uninsured by encouraging or facilitating persons (including the healthy) to purchase insurance coverage. These include: (1) the extensive health insurance reforms; (2) the new Exchanges; (3) federal premium tax credits, 26 U.S.C. § 36B; (4) federal cost-sharing subsidies, 42 U.S.C. § 18071; (5) the requirement that Exchanges establish an Internet website to provide consumers with information on insurers' plans, *id.* § 18031(d)(4)(D); (6) the requirement that employers offer insurance or pay a penalty, 26 U.S.C. § 4980H; and (7) the requirement that certain large employers automatically enroll new and current employees in an employer sponsored plan unless the employee opts out, 29 U.S.C. § 218A, just to name a few.

Second, the individual mandate has a comparatively limited field of operation vis-à-vis the number of the uninsured. In *Alaska Airlines*, the Supreme Court found that the unconstitutional legislative veto provision of the Airline Deregulation Act (permitting Congress to veto the Labor Secretary's implementing regulations) was severable because, among other things, the statute left "little of substance to be subject to a veto." 480 U.S. at 687, 107 S. Ct. at 1481. The Supreme Court noted the "ancillary nature" of the Labor Secretary's obligations and the "limited substantive discretion" afforded the Secretary.[140] *Id.* at 688, 107 S. Ct. at 1482. Thus, the limited field of operation of an unconstitutional statutory provision furnishes evidence that Congress likely would have enacted the statute without it. *Cf. Booker*, 543 U.S. at 249, 125 S. Ct. at 759 (considering whether "the scheme that Congress created" would be "so transform[ed] . . . that Congress likely would not have intended the Act as so modified to stand").

Here, as explained above, the operation of the individual mandate is limited by its three exemptions, its five exceptions to the penalty, and its stripping the IRS of tax liens, interests, or penalties and leaving virtually no enforcement mechanism. Even with the mandate, a healthy individual can pay a penalty

> and wait until becoming sick to purchase insurance.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1325 (11th Cir. 2011)

> . . .
>
> The multiple features of the individual mandate all serve to weaken the mandate's practical influence on the two insurance product reforms. They also weaken our ability to say that Congress considered the individual mandate's existence to be a *sine qua non* for passage of these two reforms. There is tension, at least, in the proposition that a mandate engineered to be so porous and toothless is such a linchpin of the Act's insurance product reforms that they were clearly not intended to exist in its absence.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1325-6 (11th Cir. 2011)

Finally the Eleventh Circuit makes the astute observation that a Congressional finding that one section of an Act is 'essential' to the operation of another, " . . . is separate, and very different, from the constitutional analysis." *Florida et al. v. Kathleen Sibelius, et al.*, 648 F.3d 1235, 1326 (11th Cir. 2011)

> The congressional language respecting Congress's constitutional authority does

not govern, and is not particularly relevant to, the different question of severability (which focuses on whether Congress would have enacted the Act's *other insurance market reforms* without the individual mandate). An example makes the point. Section 18091(a)(2)(H) of the same congressional findings provides:

Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001, *et seq.*), the Public Health Service Act (42 U.S.C. 201, *et seq.*), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market. 42 U.S.C. § 8091(a)(2)(H). By its text, § 18091(a)(2)(H) states that the individual mandate is essential to "this larger regulation of economic activity"—that is, "regulating health insurance," which it does through ERISA and the Public Health Service Act. If applied to severability, this would mean that Congress intended the individual mandate to be "essential" to, and thus inseverable from, ERISA (enacted in 1974) and the entire Public Health Service Act (or at least all parts of those

> statutes that regulate health insurance). This is an absurd result for which no party argues.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1325 (11th Cir. 2011)

We think the Eleventh Circuit is correct when it writes:

> These congressional findings do not address the one question that is relevant to our severability analysis: whether Congress would not have enacted the two reforms *but for* the individual mandate. Just because the invalidation of the individual mandate may render these provisions *less desirable*, it does not ineluctably follow that Congress would find the two reforms *so* undesirable without the mandate as to prefer not enacting them at all. The fact that one provision may have an impact on another provision is not enough to warrant the inference that the provisions are inseverable. This is particularly true here because the reforms of health insurance help consumers who need it the most. In light of all these factors, we are not persuaded that it is *evident* (as opposed to possible or reasonable) that Congress would not have enacted the two reforms in the absence of the individual mandate.

> . . .
> And where it is not evident Congress would not have enacted a constitutional provision without one that is unconstitutional, we must allow any further—and perhaps even necessary—alterations of the Act to be rendered by Congress as part of that branch's legislative and political prerogative. *See Free Enter. Fund*, 561 U.S. at __, 130 S. Ct. at 3162

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, 1326 - 7 (11th Cir. 2011)

At footnote 142 the court notes;

> . . .that the same congressional findings also state—not once, but six times—that the individual mandate operates "*together with the other provisions of this Act*" to reduce the number of the uninsured, lower health insurance premiums, improve financial security for families, minimize adverse selection, and reduce administrative costs. *See* 42 U.S.C. § 18091(a)(2)(C), (E), (F), (G), (I), (J) (emphasis added). Congress itself states that *all* the provisions of the Act operate together to achieve its goals. On this reasoning, the entire Act would be invalidated along with the individual mandate. As discussed above, this conclusion is invalid.

Florida et al. v. Kathleen Sibelius, et al., 648 F.3d 1235, fn 142 (11th Cir. 2011)

The District Court found the whole act invalid. That was an indefensible result reached by no other court. The District Court fell prey to the hyperbolic and angry political atmosphere that suggested the 'mandate' – rather than being a toothless law – was a serious abridgment of our freedoms.

> Even though the government, in arguing for the individual mandate's constitutionality, states that the individual mandate cannot be severed from the Act's guaranteed issue and community rating provisions because the individual mandate "is integral to those sections that . . . provide that insurers must extend coverage and set premiums without regard to pre-existing medical conditions." Whether a statutory provision is "integral" or "essential" to other provisions for Commerce Clause analytical purposes is a question distinct from severability. And in any event, the touchstone of severability analysis is legislative intent, not arguments made during litigation. *Florida et al. v. Kathleen Sibelius, et al.*, 648 F.3d 1235, fn 143 (11th Cir. 2011)

Health Care as a Human Right

A distinguishing feature of health care legislation is that health care is a human right. The right to broccoli is not a human right.

Nation after nation has decided to treat health care as a human right. Even the reconstituted Iraq, while under American control, in *Article 14 of its interim Constitution of 2004 says,* "The individual has the right to security, education, health care, and social security."

Similar provisions are found in the constitutions of many other nations. In the *Universal Declaration of Human Rights, Article 25* states;

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Some in Congress voted for the ACA because it recognized for the first time that health care is a right for all Americans,not just the elderly, children and disabled. It is that internationally recognized right, a right that is increasingly recognized by the American voting public, that makes this legislation distinguishable from all other legislation under the commerce clause.

Everyone needs health care at some time. The portal to receive that care is insurance coverage. The provisions of the ACA work together to fulfill our human right to adequate and affordable health care. But the 'mandate' is only one part of that Act. The remainder of the ACA also implements our human right to health care.

Conclusion

For the reasons stated herein *Amici* ask the court to affirm the Eleventh Circuit's holding on severability.

Michigan Legal Services, Inc.
By: Gary A. Benjamin, Esq. (P29103)
220 Bagley; Suite 900
Detroit, MI 48226
313-590-6136
gbenjamin@michiganlegal.org

DATED: January 26, 2012

AMICUS
CURIAE
BRIEF

FEB - 6 2012

Nos. 11-393 & 11-400

IN THE SUPREME COURT OF THE UNITED STATES

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL.,

Petitioners,

v.

KATHLEEN SEBELIUS, ET AL.,

Respondents.

STATE OF FLORIDA, ET AL.,

Petitioners,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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BRIEF OF THE MISSOURI ATTORNEY GENERAL AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS AND SEVERABILITY

CHRIS KOSTER
Attorney General of Missouri
JEREMIAH J. MORGAN
Counsel of Record
Office of the Attorney General
P.O. Box 899
Jefferson City, MO 65102-0899
(573) 751-1800
jeremiah.morgan@ago.mo.gov

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STATUTES

§ 1.330, Mo. Rev. Stat. 3

26 U.S.C. § 5000A 3

42 U.S.C. §§ 300gg *et seq.* 5

INTEREST OF AMICUS CURIAE

The Patient Protection and Affordable Care Act ("ACA") was signed into law on March 23, 2010. Among its numerous provisions, the ACA mandates that an applicable individual shall maintain "minimum essential [healthcare] coverage" or they must pay a penalty. 26 U.S.C. § 5000A. On August 3, 2010, the people of the state of Missouri overwhelmingly passed, by referendum, "Proposition C." Mo. Rev. Stat. § 1.330. Proposition C was passed in response to the ACA, and prohibits compelling "any person, employer, or health care provider to participate in any health care system." *Id.* § 1.330.1.

The ACA and Missouri's Proposition C are in conflict. Thus, the state of Missouri has an interest in the application of the ACA and in this Court's determination of the validity of its provisions under the United States Constitution. Because of the Supremacy Clause, the validity and impact of Missouri's Proposition C depends on the constitutionality of the ACA provisions with which Proposition C conflicts, as well as the severability of any conflicting provisions that may be held unconstitutional.

ARGUMENT

Should this court find the individual mandate or the new Medicaid mandate unconstitutional,[1] that finding would not require the entirety of the ACA be struck down. From providing coverage for well child visits and preventative services to establishing reasonable break times for nursing mothers, the ACA today provides benefits to Americans that are not dependent on a mandate that remains two years away.

Severance is a fundamental doctrine of judicial restraint. It derives from the notion that "when confronting a constitutional flaw in a statute, we try to limit the solution to the problem." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328 (2006). Otherwise, courts would frustrate "the intent of the elected representatives of the people" by striking an entire statute when only a portion is unconstitutional. *Id.* at 329. Indeed, "the presumption is in favor of severability." *Regan v. Time, Inc.*, 468 U.S. 641, 653 (1984). And the question in this case is whether "the balance of the legislation is incapable of functioning independently" or whether the remaining "statute will function in a *manner* consistent with the intent of Congress." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684-85 (1987) (emphasis in original). Both are satisfied here.

1/ The expanded Medicaid provisions in the ACA are also unconstitutional because they impose billions of dollars in new costs for states, and leave Missouri no option but to accept the burdens.

I. Provisions of the ACA are Capable of Functioning Independently of the Individual Mandate, and Should be Severed.

Legislation is capable of being severed if "'what is left is fully operative as a law.'" *Alaska Airlines, Inc.*, 480 U.S. at 684 (quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976)). Petitioners and their *amici* artificially construct a concept of the ACA as a piece of legislation that is so "inextricably intertwined" that "none" of the provisions "can survive without the Act's core components" – *i.e.* the individual mandate. Br. of State Petitioners on Severability, at 35. That is not the case.

Yes, the individual mandate was important to Congress in passing the ACA, and certain pieces of the ACA will not operate as Congress intended without it, particularly insurance industry reforms.[2] *See* 42 U.S.C. §§ 300gg *et seq.* (guaranteed-issue and community-rating reforms). But if the test to strike down an entire statute were whether some part will not operate the same without the unconstitutional provision, then there would be no doctrine of severability. Thus, only the invalid provision and those provisions that do not operate the same without the invalid provision should be struck down.

The ACA, however, contains over 450 provisions that address a wide variety of topics, including such provisions as student loan reforms and funding to reduce infant and maternal mortality. Some of the provisions are already effective and are successfully operating independently of the individual mandate. The following are a few examples of provisions that appear to operate independently of the individual mandate:

---

[2] This would not be the first time the Supreme Court has struck down an important provision of a statute under the Commerce Clause and left the remainder of the statute intact. Indeed, in *United States v. Morrison*, the Court struck down only one provision – the civil remedies provision – leaving the rest of the Violence Against Women Act in force. 529 U.S. 598 (2000).

Description	Statutory Section
Provides funding for maternal, infant, and early childhood visitation in order to reduce infant and maternal mortality.	ACA § 2951
Creates a Prevention and Public Health Fund.	ACA § 4002
Provides funding for school-based health centers.	ACA § 4101
Establishes nutrition labeling of standard menu items at chain restaurants.	ACA § 4205
Establishes a reasonable break time for nursing mothers and a place, other than a bathroom, which may be used.	ACA § 4207

The opponents of severability spend little time discussing or addressing the provisions of the ACA that would function (or are functioning) independently. Instead, they are willing to cast all provisions into a giant wheel as essential spokes relating either directly to the individual mandate or indirectly – as broad cost-balancing measures – to the individual mandate. There are many provisions in the ACA, such as reasonable break time for nursing mothers, that should be severed and enforced because the provisions are independent of the individual mandate.

II. Severability is Supported by the Intent of Congress, as Expressed by the Statute.

Like the independent functioning of many provisions in the ACA, the intent of Congress, as expressed by the statute, also favors severability. The question of statutory interpretation and legislative intent "begins with the plain language of the statute." *Jimenez v. Quarterman*, 555 U.S. 113, 118 (2009). Furthermore, "[w]hen 'interpreting a statute, the court will not look merely to a particular clause in which general words may be used, but will take in connection with it the whole statute (or statutes on the same subject) and the objects and policy of the law, as indicated by its various provisions, and give to it such construction as will carry into execution the will of the Legislature.'" *Carchman v. Nash*, 473 U.S. 716, 743 (1985) (quoting *Kokoszka v. Belford*, 417 U.S. 642, 650 (1974)).

Here, the statute is silent as to severability. Nevertheless, "Congress' silence is just that – silence – and does not raise a presumption against severability." *Alaska Airlines, Inc.*, 480 U.S. at 686. As such, this Court must turn to other statutory evidence to determine whether the remaining "statute will function in a *manner* consistent with the intent of Congress." *Id.* at 684-85 (emphasis in original). The most compelling evidence of such congressional intent is the very structure of the statute, and the manner in which the provisions become effective.

The ACA, with its over 450 provisions and 2,700 pages, establishes various programs and requirements that have become (and will become) effective at different times. A number of provisions went into effect immediately upon the passage of the ACA. *See, e.g.*, http://healthreform.kff.org/Timeline.aspx (noting in a timeline of implementation that 26 provisions went into effect in 2010). In 2010, for example, provisions in the ACA went into effect for the Prevention and Public Health Fund. The Department of Health and Human Services then began funding a variety of programs to help increase immunizations and to prevent tobacco use, obesity, heart disease, stroke, and cancer. The same was true in 2011, and will be true in 2012 and 2013 with the implementation of many more provisions. It is not until 2014 – after numerous provisions have been implemented and billions of dollars allocated and spent – that the provisions being challenged in this court are even slated to become effective.

Had Congress intended that the individual mandate be so central to the operation of every provision of the ACA, and that the entire law would fall if the individual mandate was held unconstitutional, then it is unlikely that so many seemingly independent provisions would have become effective years *before* the central provision became effective. And even if the justification could be made that numerous provisions were required to precede the individual mandate, surely there would have been some forethought for the unwinding of already effective provisions. This is particularly true if, as we are informed through the legislative history analysis, Congress knew full well the constitutional tightrope being walked with the individual mandate. Yet, there is no effort in the ACA to unwind or undo the already effective provisions, or the billions of dollars, that would precede the individual mandate. Accordingly, Congress intended that regardless of the individual mandate many provisions of the ACA would still "function in a *manner* consistent with the intent of Congress." *Alaska Airlines, Inc.* at 684-85 (emphasis in original).

With the exercise of judicial restraint as the fundamental doctrine of severability, and the evidence of Congressional intent from the statute itself, this Court should restrict its ruling to the individual mandate and dependent provisions. Beyond such a limited decision, this Court should allow any further, and perhaps necessary, alterations of the ACA to be rendered by Congress as part of that branch's legislative and political prerogative.

CONCLUSION

For the foregoing reasons, this Court should affirm and hold that the individual mandate and dependent provisions are severable.

Respectfully submitted,

CHRIS KOSTER
Attorney General of Missouri
JEREMIAH J. MORGAN
Counsel of Record
Deputy Solicitor General
P.O. Box 899
Jefferson City, MO 65102-0899
(573) 751-3321
jeremiah.morgan@ago.mo.gov

February 2012

Counsel for Amicus Curiae the Missouri Attorney General

AMICUS
CURIAE
BRIEF

No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, ET AL.,
Petitioners,

v.

UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Eleventh Circuit

BRIEF OF NATIONAL HEALTH LAW PROGRAM, AMERICAN ACADEMY OF PEDIATRICS, ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, EASTER SEALS, INC., NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS, NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, NATIONAL COUNCIL ON AGING AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS (SUGGESTING AFFIRMANCE ON THE MEDICAID ISSUE)

MARTHA JANE PERKINS
Counsel of Record
SARAH SOMERS
NATIONAL HEALTH LAW PROGRAM
101 EAST WEAVER ST., SUITE G-7
CARRBORO, NC 27510
(919) 968-6308
perkins@healthlaw.org

MARK REGAN
DISABILITY LAW CENTER
OF ALASKA
3330 ARCTIC BLVD.
SUITE 103
ANCHORAGE, AK 99503
(907) 565-1002

Counsel for Amici Curiae

(Amici continued on inside cover)

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

AARP, AMERICAN MEDICAL STUDENT ASSOCIATION, AMERICAN PUBLIC HEALTH ASSOCIATION, ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS, ASIAN AMERICAN JUSTICE CENTER, ASIAN PACIFIC AMERICAN LEGAL CENTER, CENTER FOR LAW AND SOCIAL POLICY, CENTER FOR MEDICARE ADVOCACY, CHILDREN'S ADVOCACY INSTITUTE, CHILDREN'S HEALTH FUND, CHILDREN'S LEADERSHIP COUNCIL, FAMILIES USA, FIRST FOCUS, HEALTH CARE FOR AMERICA NOW, MARCH OF DIMES, NATIONAL ALLIANCE ON MENTAL ILLNESS, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE, NATIONAL CENTER FOR LAW AND ECONOMIC JUSTICE, NATIONAL COUNCIL OF LA RAZA, NATIONAL COUNCIL FOR MEDICAID HOME CARE, NATIONAL DISABILITY RIGHTS NETWORK, NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL, NATIONAL LEGAL AID AND DEFENDER ASSOCIATION, NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES, NATIONAL SENIOR CITIZENS LAW CENTER, NATIONAL WOMEN'S HEALTH NETWORK, SARGENT SHRIVER NATIONAL CENTER ON POVERTY LAW, THE CHILDREN'S PARTNERSHIP, UNITED CEREBRAL PALSY, VOICES FOR AMERICA'S CHILDREN

QUESTION PRESENTED

Whether the Eleventh Circuit Court of Appeals properly held that the Medicaid expansion provisions of the Patient Protection and Affordable Care Act do not impermissibly coerce Petitioner States into continuing their participation in the Federal-State cooperative Medicaid partnership.

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INTEREST OF THE *AMICI*[1]

For more than four decades, Congress and the States have chosen to help lower-income people get the health care they need through Medicaid programs. *Amici* are health care provider and consumer organizations that have worked extensively with Medicaid programs. While each *Amicus* has particular interests, they collectively bring to the Court an in-depth understanding of how the Medicaid Act has been amended and implemented over time, at both the national and state levels. The *amici* want to bring accurate information about Medicaid's structure and history to the Court as it considers the constitutionality of the Patient Protection and Affordable Care Act (ACA) Medicaid expansion.

SUMMARY OF ARGUMENT

Beginning in January 2014, the ACA requires participating States to expand their Medicaid programs to include certain non-disabled, non-elderly individuals whose incomes are below 133% of the Federal poverty level ($14,856 for an individual in the contiguous U.S. in 2012). Contrary to Petitioner States' assertions, this expansion does not represent "an extreme and unprecedented abuse of Congress' spending power," nor does it "revolutionize" Medicaid or leave States with "no choice but to continue to participate in Medicaid." Pet. Br. at 23, 34, 18.

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[1] Counsel for the parties have filed with the Clerk blanket consents to *amicus* briefs in this case. No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money to fund preparation or submission of this brief. No person, other than *amici* and *amici*'s counsel, contributed money intended to fund preparation or submission of this brief.

The Petitioners' coercion claim is not supported by either the history or the structure of the Medicaid Act, as it was originally enacted or as Congress and the States have changed it over time. In exchange for Federal funding, participating States have always been required to provide a minimum package of benefits to certain population groups—with options to do more. Over time, as social conditions and national interests have changed, the mandates and options have changed. The ACA expansion is part and parcel of this structure.

As with previous Medicaid Act amendments, the ACA expansion neither forces States to participate in Medicaid nor forces individuals to enroll in Medicaid. Medicaid is, and always has been, voluntary for both States and individuals. Since its inception, the Medicaid "deal" has always been attractive to States—generally offering States from 50% to 83% Federal funding and sometimes 100% Federal funding. The ACA's generous Federal funding offer—100% initially and 90% thereafter—neatly reflects this Medicaid feature.

Over the years, Congress has used "maintenance of effort" requirements to assure program stability during transition periods, and the Federal agency administering Medicaid has always had the authority to deny all or partial Federal funding to a State that fails to adhere to the statutory minimums. Legally, there is nothing about the ACA Medicaid expansion that departs from past precedent.

Petitioner States say the ACA Medicaid expansion imposes "onerous new obligations." Pet. Br. at 10. Yet, the 26 States before the Court have already opted to expand their Medicaid programs to some population groups with incomes well above 133% of the Federal poverty level, and 18 States—including several of the Petitioner States—had received Federal permission to extend Medicaid eligibility to low-income non-disabled adults—and had done so—well before enactment of the ACA. And while the Petitioners complain about the "damage" that the ACA will cause, multiple studies conclude that State spending will be less with the ACA than without it.

ARGUMENT

As they did before the district court, the Petitioner States ask this Court to invalidate vital parts of a Social Security Act cooperative-federalism program without offering a "judicially manageable standard or coherent theory" for the Court to apply. *Florida ex rel. Bondi v. U.S. Dep't of Health and Human Servs.*, 780 F. Supp. 2d 1256, 1268 (N.D. Fla. 2011); *see* Resp. Br. at 35-37. Moreover, their arguments are based on incorrect and incomplete statements about how the Medicaid program works and how the ACA has amended it. As shown below, Congress has repeatedly amended the terms of Medicaid, with States that failed to implement those changes putting their entire Federal grant at risk, and the ACA in no way locks States into continuing their Medicaid participation.

I. PETITIONER STATES' ATTACK ON MEDICAID IS AN ATTACK ON MEDICAID'S FRAMEWORK AS IT HAS EXISTED OVER THE HISTORY OF THE PROGRAM.

In 1965, pursuant to its Spending Clause authority, Congress added Title XIX to the Social Security Act, thereby establishing Medicaid. *See* Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 343-52. Congress invited States to accept significant Federal funding—payment of half or more of total expenditures in a State—in return for providing health insurance coverage for specific groups of people (additional groups at State option) for a specific set of services (additional services at State option). Since 1965, Congress has amended Medicaid on numerous occasions—each time anticipating that participating States would remain in the program and spelling out what they needed to do to maintain Federal financial support. Whenever these changes have occurred, including those in the ACA, they have not altered the six major features of the program's framework:

First, Medicaid is a means-tested program that provides coverage to people who generally cannot afford to purchase private health insurance or for whom private insurance is unavailable. The Medicaid Act does not establish a "government run" health system but rather is an insurance program that enables individuals to gain access to private and public health care providers, including doctors, community health clinics, pharmacies, home health care, hospitals, and nursing homes. Medicaid's purpose is achieved through a statutory structure that entitles eligible individuals to coverage for items and services collectively known as "medical assistance."[2] Eligible individuals are not now, nor have they ever been, required to enroll in Medicaid.

Second, the Medicaid Act creates an entitlement for States that ensures that all eligible expenditures qualify for Federal funding at the appropriate Federal matching rate. This State-Federal partnership of "cooperative federalism" represents an extraordinary commitment on the part of the Federal government, which picks up at least half of the States' costs of paying for health care services and administering the program. Federal funding for expenditures typically can range from 50%-83%, with higher funding going to States with lower per capita incomes—a feature designed to ensure that Federal funds flow to States with the greatest need. *See* 42 U.S.C. §§ 1396b(a), 1396d(b). Federal funds cover at least 50% of the costs of each State's program administration, *id.* § 1396b(a)(1), and, for some activities and services,

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[2] The ACA clarifies the meaning of "medical assistance." *See* ACA § 2304 (amending 42 U.S.C. § 1396d(a)). The clarification responds to some recent court decisions that limited medical assistance to payment of a provider claim when and if it was submitted. *E.g. Okla. Ch. of Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1214 (10th Cir. 2007). As Congress made abundantly clear, the clarification was made to "correct any misunderstandings" and "to conform th[e] definition to the longstanding administrative use and understanding of the term" prior to these recent cases. *See* H.R. Rep. No. 111-299, pt. 1, 649-50 (2009); *see also* 156 Cong. Rec. H1854, H1856 (Mar. 21, 2010) (Statement of Rep. Waxman) (explaining rationale for the clarification). Thus, the clarification does not change the responsibilities States assume when they accept Federal funds, nor does it require States to directly provide medical services by establishing state-owned or operated facilities or by employing providers.

100% of the costs, *id.* §§ 1396b(a)(3)(F)(i), 1396b(a)(4), and 1396d(b) (providing full Federal funding for electronic health records development, immigrant status verification systems, and services provided through the Indian Health Service).

Third, State participation in the Medicaid program is voluntary.[3] States choosing to participate and receive Federal funding must submit a Medicaid plan to the U.S. Secretary of Health and Human Services. Once approved, a State must operate its program consistent with its plan and the Medicaid Act and regulations. *See* 42 U.S.C. § 1396a(b). While the Federal payments have always come with strings attached, "participation in the Medicaid program is entirely optional," ***Harris v. McRae***, 448 U.S. 297, 301 (1980), and an unwilling State can opt out by withdrawing its Medicaid plan, *see* 42 C.F.R. § 430.48(b)(2) (regarding repayment "[i]f the Medicaid program has been terminated by Federal law or by the State"); *see also Doe 1-13 ex rel. Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, 722 (11th Cir. 1998) (noting Medicaid is a Spending Clause program where Florida "always retains th[e] option" to withdraw).[4]

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[3] *See Florida ex rel. Bondi*, 780 F. Supp. 2d at 1268 (N.D. Fla. 2011) (citing declarations from officials in Nevada and South Dakota as evidence States understand they can terminate participation in Medicaid).

[4] Medicaid borrowed its cooperative federalism framework from the 1935 Social Security Act grant-in-aid programs, Old-Age Assistance (Title I), Aid to Dependent Children (Title IV), and Aid to the Blind (Title X). None of these programs compelled a participating State to remain in the program, any more than Medicaid did in 1965 or does now. *See Steward Mach. Co. v. Davis*, 301 U.S. 548, 612 (1937) (Sutherland, J., dissenting) ("An

In addition, if a State does not withdraw from Medicaid but fails to comply with Federal requirements, the Federal Government can impose sanctions, terminate participation, *or* withhold all or part of a State's Medicaid grant. *See* 42 U.S.C. § 1396c (providing Secretary with discretion to withhold all or part of a noncompliant State's payments); 42 C.F.R. § 430.35(d)(1)(i) (allowing Secretary to make payments "for those portions or aspects of the program that are not affected by the noncompliance"); *id.* §§ 430.60-.104 (describing withholding, notice, and appeal procedures when State fails to comply with Federal requirements). *See also, e.g.*, 42 U.S.C. § 1396b(m)(5)(B) (authorizing Secretary to deny payments to State for managed care contractors who fail to provide medically necessary

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illustration of what I regard as permissible cooperation is to be found in Title I of the [social security] act now under consideration. [W]e ... have simply the familiar case of federal aid upon conditions which the state, without surrendering any of its powers, may accept or not as it chooses."). The *amicus* brief filed by the Center for Constitutional Jurisprudence states that, in 1935, some members of Congress had doubts about whether the Social Security Act would be constitutional. Ctr. for Const. Juris. Br. 16-19. All those doubts that the *amicus* found, when placed in proper context, were about the unemployment tax-and-credit system and social security insurance and were eventually resolved in favor of their constitutionality by *Steward Machine* and *Helvering v. Davis*, 301 U.S. 619 (1937). The Social Security Act's cooperative-federalism conditional grant-in-aid programs were not challenged in those cases. As the Court would later observe in *Oklahoma v. U.S. Civil Service Comm'n*, 330 U.S. 127, 144 (1947), "[t]he offer of benefits to a state by the United States dependent upon cooperation by the state with federal plans, assumedly for the general welfare, is not unusual." *See also* Edward S. Corwin, *National-State Cooperation—Its Present Possibilities*, 8 Am. L. Sch. Rev. 687, 698-99 (1937) (tracing such programs back to 1862), cited in *Oklahoma*, 330 U.S. at 144 n. 20.

services); *id.* § 1396r(h)(3)(C)(i) (authorizing Secretary to deny payments to State for nursing facilities that are deficient); ***Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.***, 648 F.3d 1235, 1268 (11th Cir. 2011) (rejecting States' argument that refusal to participate in ACA expansion will automatically result in the loss of all Medicaid funding, finding the "Medicaid Act provides HHS with the discretion to withhold all or merely a portion of funding from a noncompliant state"); ***West Virginia v. U.S. Dep't of Health & Human Servs.***, 289 F.3d 281, 292 (4th Cir. 2002) (holding that this sort of system does not unconstitutionally coerce States).[5]

Fourth, a hallmark of the Medicaid program is the considerable discretion that States are given to tailor their programs to meet the health needs of their residents and, thus, there is considerable variation in

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[5] The language giving the Secretary discretion not to terminate the State's entire grant is no accident. As originally enacted in 1935, the Social Security Act contained "all or nothing" language that prohibited any payments to a noncompliant program. *See* Social Security Act of 1935, Pub. L. No. 74-271, §§ 4, 404, 1004, 49 Stat. 620, 622, 628-29, 646-47. In 1962, however, Congress provided the Secretary with discretion to withhold partial funding when it established a program for State aid to the aged, blind, or disabled. Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 141(a), 76 Stat. 172, 204. That language was subsequently included in the Medicaid Act. *See* Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 351. In 1968, Congress went back to the other then-existing grant-in-aid programs and amended them to allow partial payments to noncompliant States, noting that suspension of Federal funds for the entire program "is such a severe penalty that is it virtually impossible to invoke." S. Rep. No. 744, 90th Cong., 1st Sess. 169, *reprinted in* 1967 U.S.C.C.A.N. 3006.

Medicaid programs from State to State. While different and changing obligations have been enacted over time, Congress has always set a minimum floor of requirements while allowing States a great deal of flexibility in how to attain the floor and/or exceed it, including the amount and mix of services they will cover, provider payments, procedures regarding eligibility and enrollment, and program administration, such as use of managed care arrangements in lieu of traditional fee-for-service payment structures.

Fifth, as with all other Social Security Act grant-in-aid programs, Congress reserved the right to make changes over time in what participating States would need to do to continue to participate. *See* 42 U.S.C. § 1304. By the time Congress enacted Medicaid, it had on several occasions added specific conditions to the state plan requirements for the three original grant-in-aid programs. In 1950, for example, Congress required participating States to accept applications from anyone who wanted to apply and to furnish assistance to all eligible individuals with reasonable promptness. *See* Pub. L. No. 81-734, §§ 301(b), 321(b), 341(d), and 351, 64 Stat. 477, 548, 549-50, 553, and 555-56 (1950). In 1960 and 1962, Congress required programs for old age assistance and for aid to the aged, blind, or disabled to employ reasonable standards. *See* Pub. L. No. 86-778, § 601(b), 74 Stat. 924, 987 (1960); Pub. L. No. 87-543, § 141(a), 76 Stat. 172, 197 (1962). When it made these changes, Congress did not give participating States the option of turning a new requirement down and continuing to participate in the program under prior standards. Instead, the new requirements were placed in the state plan requirements section of each Act (its counterpart to Medicaid's section 1396(a)), such that a

State's failure to implement them could be met with federal compliance actions under that program's counterpart to Medicaid's 42 U.S.C. § 1396c.

Finally, as with other Spending Clause enactments, Congress and the States have used Medicaid not simply as a funding mechanism to help poor, elderly, and medically indigent Americans but also to address broader national concerns, such as reducing infant mortality, improving childhood immunization rates, improving access to costly outpatient prescription drugs, and encouraging community-based alternatives to institutional care.

II. MEDICAID'S FRAMEWORK HAS REMAINED CONSISTENT OVER TIME, WITH CONGRESS ESTABLISHING THE FLOOR OF COVERAGE—ALLOWING STATES TO DO MORE—AND REQUIRING PARTICIPATING STATES TO IMPLEMENT THEIR PROGRAMS AS FEDERAL LAW REQUIRES OR LOSE ALL OR PART OF THEIR FEDERAL MEDICAID FUNDING.

The framework described above has held true for the 46-year history of the Medicaid program, as illustrated by the following legislative reforms, including the ACA:

1965: The Medicaid Act was enacted to offer States the option to participate in a Federal-State cooperative partnership designed to improve the health access and status of poor Americans. *See* Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat. 286, 343-52 (1965) (adding Title XIX, codified as 42 U.S.C. §§ 1396-1396d). Participating states were required to make medical assistance available to low-income residents who were receiving public cash assistance—Old-Age Assistance, Aid to Families with Dependent Children (AFDC), Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to the Aged, Blind, or Disabled. *See* 42 U.S.C. § 1396a(a)(10)(A)(i). States were given options to make medical assistance available above this eligibility floor to families and people with disabilities whose incomes were too high to qualify for public cash assistance. *See id.* §§ 1396a(a)(10)(A)(ii), 1396a(a)(10)(C).

Likewise, participating States were required to cover a minimum scope of benefits, primarily hospital and nursing facility services, laboratory and X-ray services, and physicians' services. *Id.* §§ 1396d(a)(1)-(5). States could choose to receive Federal funding for a number of other, mostly non-acute, often community-based services, including outpatient prescription drugs, preventive screening services for children, and dental and home health services. *Id.* §§ 1396d(a)(6)-(15).

In addition to the eligibility and service mandates and options, the new law included protections for consumers and participating providers. For example, participating States needed to assure the Federal government that medical assistance for categorically needy individuals (persons eligible for Medicaid because their characteristics placed them in certain population categories and whose incomes and resources fell below designated thresholds) would consist of a minimum set of treatments and services. *Id.* §§ 1396a(a)(10)(A), 1396d. Similarly, States were required to assure that services would be furnished with "reasonable promptness to all eligible individuals," *id.* § 1396a(a)(8), and that individuals would receive due process when their claims were denied, *id.* § 1396a(a)(3). Congress also included a "maintenance of effort" provision in the Act that, between 1965 and mid-1969, authorized the Secretary to reduce Federal contributions to a State in rough parity to the amount that a State reduced its own contributions to Medicaid and other publicly funded programs. *See* Pub. L. No. 89-97, § 405, 79 Stat. 286, 420-21 (adding § 1117 to the Social Security Act).

Thus, the original Medicaid Act was framed to include minimum Federal requirements governing who was to be covered and what sorts of services they would receive, along with a variety of State options to exceed the Federally mandated floor. In addition, the law required some protections in the manner by which people qualified for and received services and how participating providers were to be treated. A maintenance of effort provision ensured stability as programs were being initiated. Such provisions remain an integral part of the Medicaid program today and have not been changed by the ACA.[6]

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[6] The original Medicaid Act prompted States to broaden the scope of eligibility and services available under their Medicaid plans by allowing Federal officials to withhold Medicaid grants to under-performing States. The original Act read:

> The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards

1967: Congress amended the Medicaid Act to require States to cover certain preventive screening and treatment procedures for Medicaid-eligible children under age 21, known as "early and periodic screening, diagnostic and treatment" (EPSDT) services. *See* Social Security Act Amendments of 1967, Pub. L. No. 90-248, §§ 224, 302, 81 Stat. 821, 902, 929 (then codified at 42 U.S.C. § 1396a(a)(13)). Through EPSDT, the Federal and State partnership evolved to cover well-child examinations; vision, hearing and dental care; vaccines, and services needed to address

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> with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

See Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 350 (enacting § 1903(e), codified as 42 U.S.C. § 1396b(e)). Every state but Arizona had signed on to Medicaid by October 30, 1972, when this provision was repealed, *see* Social Security Act Amendments of 1972, Pub. L. No. 92-603, § 230, 86 Stat. 1329, 1410. The House Ways and Means Committee explained the repeal as follows:

> Your committee has been concerned with the burden of the medicaid program on State finances and has included a provision in the bill which would repeal section 1903(e) from the Act. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical costs inflation, the question of required expansion of the program could then be reconsidered.

H.R. Rep. No. 92-231, at 100 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4986, 5086. So even as the legislative process was used to lift the sanction, Congress kept the door open for required expansion to take place later.

children's health problems. Thus, the service floor was raised, and all States now cover EPSDT.[7]

1972: Although Medicaid began by confining its minimum eligibility requirements to standards set by State cash welfare programs—which did and still do vary dramatically from State to State—it soon changed to provide some nationwide eligibility standards for elderly people and people with disabilities. Seven years after Medicaid's enactment, the Social Security Act Amendments of 1972 established Supplemental Security Income (SSI), a single Federal cash assistance program for low-income elderly people and people with disabilities that replaced previously State-administered cooperative-federalism programs. *See* Social Security Act Amendments of 1972, Pub. L. No. 92-603, § 209(b), 86 Stat. 1329, 1381-82 (described below) and § 301, 86 Stat. 1329, 1465-78 (replacing Title XVI of the Social Security Act); *see also* Pub. L. No. 93-233, § 13(A)(3), 87 Stat. 947 (amending 42 U.S.C. § 1396a(a)(10)(A)). Congress encouraged States to extend Medicaid to everyone who was eligible for the newly enacted SSI program. Also, all States maintained flexibility to cover people with disabilities whose incomes exceeded the SSI limits.

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[7] Congress has maintained focus on low-income children. For example, EPSDT coverage has been clarified, *see* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2263-64 (adding 42 U.S.C. § 1396d(r) and amending § 1396a(a)(43)), and strengthened to include a Federally funded pediatric vaccines program, *see* Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13631, 107 Stat. 312, 636-45 (adding 42 U.S.C. § 1396s).

Concerned that some States might exercise their right to terminate participation in the Medicaid program rather than implement the mandatory expansion, Congress gave States the option to provide Medicaid to only those aged, blind and disabled people who would have been eligible for Medicaid under the State's prior Medicaid plan—with one significant exception. *See* 42 U.S.C. § 1396a(f) (also called § 209(b)). *See* S. Rep. No. 93-553 at 55-57 (1973). Contrary to the Petitioners' characterization of this Congressional action, Pet. Br. at 3-4, Congress did not simply offer States a take-it-if-you-want option; rather, it required States electing the 209(b) option to create programs that would allow aged, blind and disabled individuals to obtain Medicaid income eligibility by deducting their expenses incurred for medical care. In other words, to maintain Medicaid participation, these States could not use a hard eligibility cut-off for the aged, blind and disabled, but would need to extend Medicaid to such individuals of any income level provided that deduction of their medical expenses qualified them for the program.

1981: In 1981, the Federal government revised coverage of long term care services in Medicaid, which were focused on institutional care, to reflect the evolving national interest in allowing individuals to live in their homes and communities. *See* Omnibus Budget Reconciliation Act (OBRA) of 1981, Pub. L. No. 97-35, § 2176, 95 Stat. 357, 812-13 (codified at 42 U.S.C. § 1396n(c)). States that elected to move their programs in the direction of community integration were required to adhere to coverage and service conditions, which, if satisfied, would result in expanded Federal funding to cover both medical and non-medical services and supports in the community.

Enrollees who needed an institutional level of care could receive these services and supports if the State provided necessary assurances to the Federal government that the coverage would be cost-effective and that enrollees' health and welfare would be protected. *Id.* Yet again, the Medicaid Act was amended to enhance State flexibility while maintaining underlying Federal standards aimed at improving the welfare of lower income people. Indeed, State community-based care innovation has flourished under these Federal standards.

1984-90: Between 1984 and 1990, Congress enacted legislation that in fundamental respects parallels the ACA's extension of coverage to non-disabled, non-elderly adults. Over this time period and through a series of incremental reforms, Congress established a national floor of coverage for children, pregnant women, and the aged and disabled. This minimum was accompanied by options for States to reach further, but a solid floor existed nonetheless. Reforms that began as options ultimately became mandatory, as follows:

A. Children and pregnant women

Prior to 1984, as noted above, participating States were required to extend Medicaid to children and pregnant women receiving cash assistance through the AFDC program. States were given the option to extend coverage to children, including unborn children, with AFDC-level income but living in families that did not qualify for cash assistance, typically because of the presence of two parents in the household. In 1984, this optional coverage was made mandatory for children under age five and first-time pregnant women who met the financial eligibility standards for the State's AFDC program. *See* Deficit Reduction Act (DRA) of 1984, Pub. L. No. 96-369, § 2361, 98 Stat. 494, 1104 (codified at 42 U.S.C. §§ 1396d(n), 1396a(a)(10)(A)(i)(III)). In 1985, States were required to cover all pregnant women who met the financial eligibility criteria for AFDC. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9501, 100 Stat. 82, 201 (amending 42 U.S.C. § 1396d(n)(1)). A year later, in 1986, the Medicaid Act was amended to give States the option to cover pregnant women and young children with low family incomes that nevertheless exceeded AFDC payment levels. *See* OBRA of 1986, Pub. L. No. 99-509, § 9401, 100 Stat. 1874, 2050 (codified at 42 U.S.C. §§ 1396a(l), 1396a(a)(10)(A)(ii)). As part of this new option, Congress sought to protect low-income families whose eligibility was tied to the AFDC program and, thus, included a maintenance of effort provision prohibiting States from taking up the new Medicaid option if they were reducing AFDC payment levels below their 1986 standards. *See id.* § 9401(b) (adding 42 U.S.C. § 1396a(l)(4)(A)); *see* H.R. Rep. No. 99-727, at 99-100, *reprinted in* 1986 U.S.C.C.A.N. 3689-90; *see also* Pub. L. No. 100-203, § 4101(e)(4), 101 Stat. 1330-140, 1330-142 (1987) (amending 42 U.S.C. § 1396a(l)(4)(A)).

In 1988, Congress began to transform these options into requirements, through phased-in coverage tied to the Federal poverty level, rather than the AFDC program. Coverage ultimately reached all children, birth to age 5, and pregnant women with family incomes under 133% of the Federal poverty level and, in the case of children aged 5-18, with family incomes under 100% of the poverty level. *See* Medicare Catastrophic Coverage Act of 1988 (MCCA), Pub. L.

No. 100-360, § 302, 102 Stat. 683, 750 (codified at 42 U.S.C. §§ 1396a(a)(10)(A)(i)(IV), 1396a(l)(2)(A)(iii)); OBRA of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2106, 2258 (amending 42 U.S.C. §§ 1396a(a)(10)(A)(i), 1396a(a)(A)(10)(A)(ii), 1396a(l)); OBRA of 1990, Pub. L. No. 101-508, § 4601(a)(1), 104 Stat. 1388, 1388-166. During this time, Congress allowed States, as it had during previous years, to extend benefits to needy children and pregnant women with incomes above the minimum coverage floors. *Id.*

Congress enacted all of these mandatory requirements as amendments to 42 U.S.C. § 1396a—thus exposing a State that refused to implement them to the risk of losing all or part of its Medicaid grant under § 1396c. In fact, on one occasion, to assure programmatic stability, Congress included a maintenance of effort provision that temporarily conditioned the entire Medicaid grant on the States' maintenance of AFDC payment levels at the 1988 levels. *See* 42 U.S.C. § 1396a(c)(1) (providing that "the Secretary shall not approve any State plan for medical assistance if the State has in effect [AFDC] payment levels that are less than the payment levels in effect under such plan on May 1, 1988"), repealed by Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 114(d), 110 Stat. 2105, 2180.

Additionally, to facilitate enrollment of these populations, the 1990 Congress required States to assure that their Medicaid applications would be accepted not only at welfare offices but also at health care sites frequented by low-income children and pregnant women, such as community health clinics and hospitals. *See* 42 U.S.C. § 1396a(a)(55) (added by

OBRA of 1990, § 4602)). Beyond this requirement, the Act permitted States to allow Medicaid-participating providers to make "presumptive eligibility" determinations and obtain Federal funding for services at the earliest possible time and without penalty if the child or woman was later found not to be Medicaid eligible. *See* 42 U.S.C. §§ 1396r-1 (optional presumptive eligibility for pregnant women, added in 1986); 1396r-1a (optional presumptive eligibility for children, added in 1997).[8]

B. Aged, blind and disabled individuals

During this same time period, Congress and the States addressed eligibility floors for low-income elderly and disabled people, once again beginning with options that later were transformed into basic requirements, with flexibility for States regarding how these requirements would be achieved and to offer more than was minimally required.

For example, lower-income elderly people and people with disabilities who were eligible for Medicare typically needed help to meet that program's cost sharing. The 1965 Medicaid Act authorized States to make Medicare Part A premium payments and Part B cost-sharing payments for Medicaid recipients, as well as Part B premium payments on behalf of low-income recipients of cash benefits. *See* Pub. L. No. 89-97, §§ 121, 122, 79 Stat. 286, 353 (codifying then 42 U.S.C. § 1396a(a)(15)). In 1986, Congress created a new

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[8] *Cf.* 42 U.S.C. § 1396r-1(e) (optional presumptive eligibility for non-disabled, non-elderly adults, added by ACA § 2001(a)(4) (effective 2014)).

Medicaid option through which States could receive Federal payments toward coverage of Medicare cost-sharing for people whose incomes were at or below a State-specified threshold at or below the Federal poverty line. *See* OBRA of 1986, Pub. L. No. 99-509, § 9403, 100 Stat. 1874, 2053 (adding 42 U.S.C. §§ 1396d(p), 1396a(a)(10)(E)). Two years later, Congress converted the option into a requirement for States to phase in coverage of at least Medicare premiums and cost-sharing for all persons with incomes below the poverty line. *See* MCCA, Pub. L. No. 100-360, § 301, 102 Stat. 683, 748 (amending 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(p)).

In 1990, Congress required States to phase-in Medicare cost-sharing for people with family incomes up to 120% of the poverty line, with the phase-in to be fully effective by 1995. *See* OBRA of 1990, Pub. L. No. 101-508, § 4501, 104 Stat. 1388, 1388-164 (amending 42 U.S.C. §§ 1396b(a)(10)(E)(ii), 1396d(p)(2)). Finally, in § 4732 of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251, Congress created the "Qualified Individual" program, through which most States provide cost-sharing assistance to Medicare beneficiaries with incomes up to 135% of the poverty level. Before this, President Reagan had developed and Congress had enacted an option for States to ignore parental income of any amount and provide Medicaid to disabled children in their homes rather than institutions. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 134, 96 Stat. 324, 375 (adding 42 U.S.C. § 1396a(e)(3)). All of these changes were enacted as amendments to 42 U.S.C. § 1396a—and so all of them triggered complete or partial defunding, under 42 U.S.C. § 1396c, of a State that refused to implement one of them or, in the case of the TEFRA option, purported to implement but failed to do so.

Also during this time period, the Medicaid Act was amended to address broad national concerns for the aged, blind, and disabled. In response to a series of studies identifying "grossly inadequate care and abuse of residents" in nursing homes, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* at 3 (1986), Congress added provisions commonly known as the Nursing Home Reform Act. *See* 42 U.S.C. § 1396r (added by OBRA of 1987, Pub. L. No. 100-203, §§ 4211-13, 101 Stat. 1330, 1330-182-1330-219). Among other things, these provisions require Medicaid-funded nursing facilities to provide services in accordance with individualized written plans of care, use only properly trained nursing aides, and engage in preadmission screening to ensure that individuals with mental illness or intellectual disabilities are not improperly placed in nursing facilities. *Id.*

1993–2009: The 1993 to 2009 time frame saw Congress further enhancing States' options for operating their Medicaid programs, for example providing States significant leeway to use Federal funds to provide Medicaid services through managed care delivery systems, such as HMOs. *See, e.g.,* 42 U.S.C. § 1396u-2 (added by Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4701(a), 111 Stat. 251, 489-92) (authorizing state plan amendments to require mandatory enrollment in managed care entities).

In another significant change, Congress required participating States to be involved in a broad effort to improve access to outpatient prescription drugs. As of January 2006, individuals who qualify for both

Medicare and Medicaid are automatically enrolled in Medicare Part D. *See* 42 U.S.C. §§ 1395w-101-134, 1396u-5 (added by Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2006, 2071-2131). As a condition of its State plan and receipt of any Federal funding, a State must screen individuals for dual eligibility and offer them enrollment in the State plan. *See* 42 U.S.C. § 1396u-5(a)(3). States must also reimburse the Federal government for prescription drug costs based on State-specific enrollment in Part D of people eligible for both Medicare and Medicaid. *See id.* § 1396u-5(c).

There is also ample precedent from this time period for Medicaid coverage of low-income non-disabled and non-elderly adults (the population group assisted by the ACA Medicaid expansion). Since Medicaid's inception, States have been authorized to obtain Federal funding to implement Medicaid demonstration projects. *See* 42 U.S.C. § 1315. States began to use this option in the mid 1990s to extend Medicaid coverage to non-disabled and non-elderly adults whose incomes fall below a State-set percentage of the Federal poverty level. By 2008, 18 States had received Federal permission to extend coverage to these adults using Federal Medicaid funds, including Petitioners Arizona, Idaho, Indiana, Iowa, Maine, Michigan, and Utah. *See* Keavney Klein & Sonya Schwartz, Nat. Acad. for State Health Pol., *State Efforts to Cover Low-Income Adults Without Children* 3 (Sept. 2008); *cf.* James F. Blumstein & Frank L. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 Vand. L. Rev. 125, 270 (2000) (suggesting Tennessee's § 1315 program as a "model of broader health care reform—achieving broader access goals by recapturing and reallocating Medicaid savings for improved access for uninsured and uninsurable (but not Medicaid eligible) beneficiaries").

In the final major Federal legislation pre-dating the ACA, Congress enacted the American Recovery and Reinvestment Act (ARRA), which included provisions to strengthen use of health information technology. As part of this effort, ARRA made Medicaid funds available to States—at a 100% Federal match—for expenditures to help Medicaid-participating providers establish electronic health records systems. *See* 42 U.S.C. §§ 1396b(a)(3)(F), 1396b(t). ARRA also included a maintenance of effort provision that provided States enhanced Federal matching rates to maintain their Medicaid eligibility levels during the economic recession in 2010 and part of 2011. To receive the enhancement, States could not shift Medicaid costs onto cities or counties, delay payments to providers, deposit the enhanced payments into a rainy day fund, or reduce eligibility standards below those in effect on July 1, 2008. *See* ARRA, Pub. L. No. 111-5, § 5001(f), 123 Stat. 115, 499-500 (2009).

III. THE AFFORDABLE CARE ACT DOES NOT CHANGE MEDICAID'S FRAMEWORK: MEDICAID REMAINS VOLUNTARY FOR STATES AND INDIVIDUALS, AND FEDERAL AUTHORITY TO WITHHOLD ALL OR PART OF A NONCOMPLYING STATE'S GRANT HAS NOT CHANGED.

In 2010, the United States Congress, including a super-majority of the Senate, enacted the ACA. In the context of covering America's uninsured, the ACA

Medicaid expansion was neither substantial nor unforeseeable. The Medicaid provisions are a step towards better health care coverage and better health for low-income people, and this is just another step along the same path Medicaid has followed for the past 46 years.

Simplified rules for who is eligible, with no requirement to apply for public cash assistance in order to get health care: Over time, Medicaid has provided coverage to low-income children, pregnant women, elders and people with disabilities on the basis of their incomes, not their receipt of public welfare cash assistance. For more than 15 years, all States have been required to provide coverage for young children and pregnant women whose family incomes are at or below 133% of the poverty level, and for more than 10 years, most States have been required to provide Medicaid coverage of Medicare cost sharing amounts for beneficiaries with family incomes below 135% of poverty. Now, beginning in 2014, the ACA adjusts the Medicaid eligibility floor so that States not already doing so will extend coverage to non-disabled, non-elderly adults with family incomes below 133% of the poverty level. States have the option to implement the expansion early (and some states are doing so). As is typical for the Medicaid program, States retain options to provide additional coverage beyond the Federal floor. As has previously been the case, the Federal Secretary maintains discretion to withhold all or partial funding to a State that is failing to comply with the Federal mandates.[9]

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[9] Petitioners' theory that Federal discretion is not available with respect to the ACA's Medicaid expansion, Pet. Br. at 35-36 n.15,

Federal consideration for State budgets: The ACA contains exceptionally generous Federal funding to cover the costs associated with expanding coverage. At its outset in 2014, the improved Medicaid access will be entirely Federally funded. Even after State participation in funding is fully phased in by 2020, States will only be responsible for 10% of the costs associated with the expansion group. *See* 42 U.S.C. § 1396d(y)(1). The Federal government will also pay

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rests on a misunderstanding of what the Court of Appeals actually held, what 42 U.S.C. § 1396c says, and what the Federal Government has actually argued. The Court of Appeals did not say that the Act "leaves the Secretary with discretion to allow States to continue participating in Medicaid without abiding by the ACA's new terms." It said, correctly, that "the Medicaid Act provides HHS with the discretion to withhold all or merely a portion of funding from a noncompliant state." 648 F.3d at 1268. How large a withheld "portion" might need to be to ensure State compliance with this particular Medicaid mandate is, per the text of § 1396c, initially a matter of the Secretary's "discretion," perhaps "limit[ing payments] to categories under or parts of the State plan not affected by such failure," perhaps focused on the Federal match for State administrative costs. *See West Virginia*, 289 F.3d at 293, n.8 (4th Cir. 2002). In *West Virginia*, the Federal Government described a range of possible sanctions, and nowhere in its briefing here or below has it asserted that this range of possible sanctions, up to and including complete defunding, would not be available to deal with a State attempt to stay in Medicaid but refuse to comply with the program's statutory terms. *See also* Resp. Br. at 4, 40-41. So far as *amici* are aware, the *West Virginia* case is the only reported case (other than the Eleventh Circuit decision under review) in which a court has accepted that the coercion doctrine applies to Medicaid, considered a State's contention that "the federal government would withhold *all* of [a State's] federal Medicaid funds unless [the State] implemented [a newly mandatory part of the Medicaid] program," *id.* at 291, rejected that contention, and determined that Medicaid is or is not unconstitutionally coercive.

90% of the funding necessary for State development of new Medicaid eligibility systems through 2015. *See* 76 Fed. Reg. 21,950 (Apr. 19, 2011).[10]

Additionally, as it has on previous occasions, Congress included a "maintenance of effort" provision to discourage States from dropping coverage between now and 2014. Like the 1988 maintenance provisions, the ACA provision forbids a State from reducing eligibility standards below standards in effect on a certain date (the ACA's enactment), on condition of not receiving Medicaid payments. *See* ACA § 2001(b) (codified at 42 U.S.C. §§ 1396a(a)(74), 1396a(gg)). As with previous maintenance provisions, the ACA requirement is temporary and will expire on January 1, 2014 (2019 for children), after which States will be free to reduce optional Medicaid eligibility. The ACA also includes a feature that allows a State to reduce Medicaid eligibility to certain non-disabled adults if it certifies to the Secretary that it has a "budget crisis" or projects a budget deficit. *Id.* (*Amici* are aware of only three States, Hawaii, Maine, and Wisconsin, that have sought this relief.)

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[10] Petitioners complain that the ACA's Medicaid provisions will force them to spend more money, but they have not argued that the provisions are unconstitutional unfunded mandates, and such an argument would not be well taken. Pet. Br. at 16-17. The statute that makes Members of Congress politically accountable in this situation is the Unfunded Mandates Reform Act of 1995, Pub. L. No. 104-4, 109 Stat. 48. Senator Corker raised a point of order under this Act against the ACA's Medicaid provisions. *See* 155 Cong. Rec. S13803-04 (daily ed. Dec. 23, 2009). In response, Senator Baucus referred to the ACA's initial 100% and ultimate 90% federal funding for the extension of Medicaid coverage and said that this is a very fair deal for States. The Senate rejected the point of order by a vote of 55-44. *See* 155 Cong. Rec. S13831 (daily ed. Dec. 23, 2009).

State options to cover additional home and community-based services: As noted above, Medicaid has always provided for a mix of mandatory and optional eligibility categories and mandatory and optional services and, since 1981, has included State options for covering additional home and community-based services. The ACA establishes several new State options to obtain Federal funds for dynamic, innovative programs for covering long-term care and home care for older people and people with disabilities. *E.g.,* ACA § 2401 (Community First Choice), ACA § 2403 (Money Follows the Person Rebalancing). The ACA also expands an existing system for renewing Medicaid waivers that serve people who get both Medicaid and Medicare and establishes a Federal office for coordinating coverage for people who get benefits under both programs. ACA §§ 2601 and 2602.

Voluntary participation by States and by individuals: Medicaid enrollment remains voluntary for States and for individuals. Congress left Medicaid enrollment voluntary for individuals precisely because the program is voluntary for States: Congress could not require low-income people to enroll, since no State needs to participate in Medicaid. As has been the case over the entire history of the Medicaid program, the consequences of State withdrawal would be harsh for a State's low-income residents and people with disabilities, but the reality is that the entire system remains voluntary for the poorest U.S. residents.

According to the Petitioners, "State participation in Medicaid is not a matter open to choice," because:

Minimum essential coverage requirements reach all but exempt persons; Medicaid is an identified form of minimal essential coverage; and individuals with incomes below 100% of poverty are not eligible for advance premium tax credits through State Exchanges. Thus, according to Petitioners, Medicaid becomes the only option for fulfilling the minimum coverage requirement, and this "lack of a contingency plan" must mean that Congress "transformed" Medicaid to "a program to provide a minimum level of coverage to every needy person." Pet. Br. at 34-35. There are a number of problems with this construct. First, it is not true that Medicaid is the only source of coverage for low-income people; many of them will satisfy the mandate with Medicare, care through the Veterans' Administration, other types of government-financed care, or employer-provided insurance. *See* 26 U.S.C. § 5000A(f)(1) (listing seven government programs as satisfying "minimum essential coverage"). Second, the vast majority of individuals who will be eligible for Medicaid in 2014 and thereafter will face no penalties in the absence of Medicaid for failing to obtain minimum essential coverage, either because their incomes are below the federal income tax filing threshold, because the required contribution for an available policy will exceed eight percent of their incomes,[11] or because they can obtain a hardship exception. *See* 26 U.S.C. §§ 5000A(e)(1), (e)(2), (e)(5) (describing these as exemptions from minimum essential coverage requirements).

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[11] *See* Resp. Br. at 49 & n. 22 (correctly suggesting that a newly eligible individual with income at 138% of the poverty level will never be able to afford the least expensive, bronze policy). Using 2010 figures, 8% of that person's yearly income would be $1195, *id.*, but "[a] Bronze plan in 2016 will cost an individual between $4,500 and $5,000 a year." 156 Cong. Rec. S2069, 2081 (daily ed. Mar. 25, 2010) (Statement of Sen. Durbin) (citing Letter from

Third, Petitioners' argument does not change the reality that Medicaid is—as it has always been—voluntary for States and low-income individuals. Whatever happens to poor people in a State that opts to leave Medicaid rather than expand it, "this is the headache that Congress created for itself by excluding this population from the Act's premium tax credit and Exchange provisions." Sara Rosenbaum & Katherine Hayes, *The Misleading Arguments in the States' Medicaid Coercion Brief*, The Health Affairs Blog (Jan. 19, 2012).[12] As Professors Rosenbaum and Hayes conclude,

> One could argue that Congress should not have made so many operational and policy assumptions about the deal it was offering.... One might take the position ... that Congress should have anticipated an exodus by some states and created a fallback system of ... coverage ... for poor people living in states that choose not to participate in Medicaid. This might have been a viable policy choice, not to mention the moral and ethical thing as a means

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Cong. Budget Office to Hon. Olympia Snowe 2 (Jan. 11, 2010), available at http://www.cbo.gov/ftpdocs/108xx/doc10884/01-11-Premiums_for_Bronze_Plan.pdf).

[12] http://healthaffairs.org/blog/2012/01/19/the-misleading-arguments-in-the-states-medicaid-coercion-brief/.

> of assuring that most Americans truly will have access to affordable insurance coverage. Congress did not make that choice however....

Id.

In sum, while altered over its history to improve health access for poor people, the Medicaid bargain remains much the same today, after passage of the ACA, as it was in 1965. The Medicaid Act continues to provide States an entitlement to Federal funding for administration and services provided through the Medicaid program. Participation is not compulsory. To participate, States must adhere to minimum federal requirements with respect to eligibility, services, and program administration. Beyond the floor, States have considerable discretion in how they will implement the Federal requirements and to decide whether to go beyond what the Federal law requires.

IV. MEDICAID SPENDING IS WHAT IT IS BECAUSE STATES HAVE AGGRESSIVELY TAKEN UP FEDERAL OPTIONS, AND STATES' SAVINGS UNDER THE AFFORDABLE CARE ACT WILL EXCEED THEIR COSTS.

The Petitioner States argue that the sheer size of the Medicaid program has grown significantly over time. This growth is due in large part to options the States themselves chose.

At the time of the program's start, States made unexpectedly great use of Medicaid options—choosing to expand their programs beyond the minimum coverage floors established in the Medicaid Act to include groups and services that Congress did not require them to cover. See John D. Klemm, ***Medicaid Spending: A Brief History***, 22 Health Care Fin. Rev. 105, 106 (Fall 2000).[13] This State uptake of options has become a consistent hallmark of the program over time. In fiscal year 2007, 60.4% of all Medicaid spending was attributable to States' optional expenditures on mandatory populations and expenditures on optional populations. *See* Kaiser Family Foundation, ***Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options*** 17 (Jan. 2012 Update).[14] As is typical for Medicaid, there is variation among the States. For example, 76.5% of expenditures in Petitioner North Dakota are attributable to this optional spending; 74.7%, in Ohio; 74%, in Wisconsin; 69.4%, in Iowa; 69.2%, in Maine; 67.4%, in Nebraska; 61.5%, in Indiana; 53%, in Florida. *Id.*

Eighteen of the Petitioner States–all but Alabama, Colorado, Idaho, Nevada, North Dakota, South Dakota, Utah, and Wyoming–provide, as a matter of State option, Medicaid coverage for at least some groups of children or pregnant women that exceeds the 100%/133% Federal poverty-level minimums. *See id.* at 14. In addition, all 26 of the Petitioner States' Medicaid programs cover, as a matter of State option, at least some elderly people and/or people with disabilities with incomes up to about 224% of Federal poverty level.[15] The Petitioner State officials should not be heard to complain now that the Medicaid program is too large—for its size is due, in large part, to choices the States themselves have made to expand coverage through Federal funding options that Congress made available to them over the last 46 years as participants in the Medicaid program.

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[13] Available at https://www.cms.gov/HealthCareFinancingReview/Downloads/00fallpg105.pdf.

[14] Available at http://www.kff.org/medicaid/upload/8239.pdf.

Moreover, independent analyses have concluded that total State savings will exceed new costs under the ACA. *See* Resp. Br. at 11, 26-29. Among other things, savings will be attributable to increased Federal matching percentages offered under the ACA, reductions in Medicaid enrollment of people who become covered under employer-sponsored plans, and reductions in State funding of safety-net providers, such as community clinics and public hospitals, due to the expansion in insurance coverage. The ACA will roughly halve State spending on uncompensated care for uninsured people, collectively saving $26 billion to $52 billion, and reduce State spending on individuals with mental illness, collectively saving between $11 billion and $22 billion from 2014-2019. *See* Matthew

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[15] Table 11 of the Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* 98-99 (Mar. 2011), available at http://www.macpac.gov/reports, shows that 23 of the 26 States cover individuals needing a nursing home level of care with incomes at 224% of poverty. Of the 3 remaining States, Alaska and Nebraska cover working individuals with disabilities with family incomes up to 250% of poverty, Alaska Stat. § 47.07.020(b)(12), Neb. Rev. Stat. § 68-915(8), while North Dakota covers workers with disabilities with family incomes up to 225% of poverty, North Dakota Century Code § 50-24.1-02.7. Alaska has recently restored the 300%-of-SSI long-term-care eligibility system used in the other 23 Petitioner States, *see* Alaska Stat. § 47.07.020(b)(6).

Buettgens, Stan Dorn, & Caitlin Carroll, The Robert Wood Johnson Found. and Urban Inst., *Consider Savings as Well as Costs* 2 (July 2011).[16]

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[16] Available at http://www.urban.org/UploadedPDF/412361-consider-savings.pdf. In 2009, the Council of Economic Advisers estimated costs and savings in 16 states, including Florida, Idaho, Indiana, Iowa, Maine, Michigan, Nebraska, Pennsylvania, and Wyoming, and concluded that "the saving to state governments from health insurance reform is substantial,... with the savings more than offsetting the additional Medicaid costs in every one of the sixteen states." Council of Econ. Advisers, *The Impact of Health Insurance Reform on State and Local Governments* 7 (Sept. 15, 2009), available at http://www.whitehouse.gov/assets/documents/documents/cea-statelocal-sept15-final.pdf. Only 12 of the 26 Petitioner States submitted evidence to the district court on the cost of the ACA Medicaid expansion, and only 3 of the States attempted to rebut the suggestion by the Council that there would be net overall savings. *Cf.* Maryland Health Care Reform Coordinating Council, *Final Report and Recommendations* 4-5 (Jan. 1, 2011) (projecting "substantial savings to Maryland's budget over the next ten years"), available at http://dhmh.maryland.gov/healthreform/pdf/110110FINALREPORT.pdf; Center for Health Law and Econ. & Blue Cross Blue Shield of Massachusetts, *Re-Forming Reform* 23 (estimating $300 million/year savings in Medicaid alone between 2014-2019), available at http://bluecrossfoundation.org/Policy-and-Research/Reports-By-Topic/National-Health-Reform/~/media//Files/Publications/Policy%20Publications/062110NHRReportFINAL.pdf; N.M. Voices for Children, *The Tax Revenue Benefits of Health Care Reform in New Mexico* at 2-3, 5-6 (Aug. 2011) (projecting that cost of Medicaid expansion 2014-2020 will be more than offset by anticipated state revenues), available at http://www.nmvoices.org/wp-content/uploads/2011/08/Tax-rev-benefits-of-aca-8-11.pdf; Okla. Policy Inst., *Health Care Reform and the State Budget: Savings Likely to Partly or Fully Offset Modest New Costs* (Oct. 2011) (citing RWJF estimate of net $60 million cost to $367 million savings over 2014-2019 and refuting cost projections of Cato Institute and Oklahoma Council of Public Affairs), available at http://okpolicy.org/files/StateHealthCareCost

CONCLUSION

The Court should affirm the Eleventh Circuit's decision upholding the constitutionality of the ACA Medicaid expansion, thereby ensuring that Medicaid can play its proper role in helping lower-income people get the health care they need in States that choose to participate in the program.

Dated: February 15, 2012

Respectfully submitted,

Martha Jane Perkins
Counsel of Record
Sarah Somers
National Health Law Program
101 E. Weaver St., Suite G-7
Carrboro, NC 27510
(919) 968-6308
perkins@healthlaw.org

Mark Regan
Disability Law Center of Alaska
3330 Arctic Blvd., Suite 103
Anchorage, Alaska 99503
(907) 565-1002
mregan@dlcak.org

Counsel for Amici Curiae

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AMICUS
CURIAE
BRIEF

Nos. 11-393 & 11-400

IN THE
Supreme Court of the United States

NATIONAL FEDERATION OF
INDEPENDENT BUSINESS, ET AL.
Petitioners,
v.
KATHLEEN SEBELIUS, SECRETARY OF HEALTH
AND HUMAN SERVICES, ET AL.
Respondents.

STATES OF FLORIDA, ET AL.,
PETITIONERS HHS, NO. 11-400

FLORIDA, ET AL,
Petitioners,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.
Respondents.

**On Writs of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit**

BRIEF OF *AMICI CURIAE* OF THE NATIONAL INDIAN HEALTH BOARD; ET AL, IN SUPPORT OF RESPONDENT UNITED STATES ON SEVERABILITY ISSUE

(Additional Amici Listed on Inside Cover)

GEOFFREY D. STROMMER *
CAROL L. BARBERO
VERNON L. PETERSON
ELLIOTT MILHOLLIN
WILLIAM R. NORMAN
JESSICA M. WILES
HOBBS, STRAUS, DEAN &
WALKER, LLP
806 SW Broadway, Suite 900
Portland, Oregon 97205
(503) 242-1745
GStrommer@hobbsstraus.com

* Counsel of Record
January 27, 2012

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

Additional Amici:

AFFILIATED TRIBES OF NORTHWEST INDIANS; AK-CHIN INDIAN COMMUNITY; ALASKA NATIVE HEALTH BOARD; ALL INDIAN PUEBLO COUNCIL; BRISTOL BAY AREA HEALTH CORPORATION; CHEROKEE NATION; CHICKASAW NATION; CITIZEN POTAWATOMI NATION; COMANCHE NATION; CONSOLIDATED TRIBAL HEALTH PROJECT, INC.; COQUILLE TRIBE OF OREGON; COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS; GREAT PLAINS TRIBAL CHAIRMAN'S ASSOCIATION; HO-CHUNK NATION; HOOPA VALLEY TRIBE; INTER TRIBAL COUNCIL OF ARIZONA, INC.; JAMESTOWN S'KLALLAM TRIBE OF WASHINGTON; KAW NATION; KLAMATH TRIBES; KOOTENAI TRIBE OF IDAHO; LUMMI NATION; LYTTON RANCHERIA OF CALIFORNIA; MANIILAQ ASSOCIATION; MENOMINEE INDIAN TRIBE OF WISCONSIN, METLAKATLA INDIAN COMMUNITY; MISSISSIPPI BAND OF CHOCTAW INDIANS; MONTANA-WYOMING TRIBAL LEADERS COUNCIL; NATIONAL CONGRESS OF AMERICAN INDIANS; NEZ PERCE TRIBE; NORTHERN VALLEY INDIAN HEALTH, INC.; NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD; NORTON SOUND HEALTH CORPORATION; PALA BAND OF LUISENO MISSION INDIANS; PAWNEE NATION OF OKLAHOMA; PRAIRIE BAND POTAWATOMI NATION; SEMINOLE TRIBE OF FLORIDA; SQUAXIN ISLAND TRIBE OF THE SQUAXIN ISLAND RESERVATION; SUQUAMISH INDIAN TRIBE; SUSANVILLE INDIAN RANCHERIA; SWINOMISH INDIAN TRIBAL COMMUNITY; TONKAWA TRIBE OF INDIANS OF OKLAHOMA; AND THE UNITED SOUTH AND EASTERN TRIBES, INC.

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GLOSSARY OF ACRONYMS

ACA	**Patient Protection and Affordable Care Act**
AFA	**Annual Funding Agreement**
DHHS	**Department of Health and Human Services**
IHCIA	**Indian Health Care Improvement Act**
IHS	**Indian Health Service, an Agency of the DHHS**
ISDEAA	**Indian Self-Determination & Education Assistance Act**

INTEREST OF *AMICI*[1]

The 449 tribes across the nation who are *amici* or members of *amici* tribal organizations represented on this brief are direct beneficiaries of several Indian-specific provisions included in the Patient Protection and Affordable Care Act ("Act" or "ACA")[2] that have a purpose and genesis separate and distinct from the minimum coverage provision that the Eleventh Circuit Court of Appeals declared unconstitutional but severable from remaining provisions of the Act.[3] The Indian-specific provisions of the ACA are legally separable from the remainder of the Act, because they solely relate to the Federal responsibility to provide health care to Indian tribes and their members, and are of critical importance to the delivery of health care services to Indian tribes and their members throughout the country.

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[1] No counsel for a party authored this brief in whole or part, and no person other than *amici* made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of amicus curiae briefs through letters of consent on file with the Clerk.

[2] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[3] The Eleventh Circuit Court of Appeals decision is reported at *Florida ex rel. Atty. Gen. v. United States Department of Health and Human Services*, 648 F.3d 1235 (11th Cir. 2011) *cert. granted*, 132 S. Ct. 603 (U.S. 2011) and *cert. granted*, 132 S. Ct. 604 (U.S. 2011) and *cert. granted in part*, 132 S. Ct. 604 (U.S. 2011). The district court decision is reported at *Florida ex rel. Bondi v. United States Department of Health and Human Services*, 780 F. Supp. 2d 1256 (N.D. Fla. 2011) *order clarified*, 780 F. Supp. 2d 1307 (N.D. Fla. 2011), *aff'd in part, rev'd in part sub nom. Florida ex rel. Atty. Gen. v. United States Department of Health and Human Services*.

Amici include federally-recognized tribes and tribal organizations from across the nation, many of which are located in the Petitioner states.[4]

The National Indian Health Board (NIHB) represents tribal governments—both those that operate their own health care delivery systems through contracting and compacting under the Indian Self-Determination and Education Assistance Act ("ISDEAA"), and those receiving health care directly from the Indian Health Service. Its Board of Directors is made up of tribal member representatives from twelve Area Health Boards which are organized to correspond to the twelve IHS service areas. NIHB provides a variety of services to tribes, the Area Health Boards, tribal organizations, federal agencies, and private foundations, including advocacy, policy development, research and training on Indian health issues, and tracking legislation and regulations.

The National Congress of American Indians (NCAI), founded in 1944, is the oldest, largest and most representative American Indian and Alaska Native organization serving the broad interests of tribal governments and communities. NCAI is comprised of more than 200 American Indian tribes and Alaska Native villages and other associated organizations. NCAI's mission is to inform the public and all branches of the federal government about tribal self-government, treaty rights, and a broad range of federal policy issues affecting tribal governments.

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[4] One or more of *amici* tribes or tribes who are members of *amici* tribal organizations are located within 23 of the 26 Petitioner states. No federally-recognized tribes are located in Georgia, Ohio or Pennsylvania.

Amici Ak-Chin Indian Community; Cherokee Nation; Chickasaw Nation; Citizen Potawatomi Nation; Comanche Nation; Coquille Tribe of Oregon; Ho-Chunk Nation; Hoopa Valley Tribe; Jamestown S'Klallam Tribe of Washington; Kaw Nation; Klamath Tribes; Kootenai Tribe of Idaho; Lummi Nation; Lytton Rancheria of California; Menominee Indian Tribe of Wisconsin, Metlakatla Indian Community; Mississippi Band of Choctaw Indians; Nez Perce Tribe; Pala Band of Luiseno Mission Indians; Pawnee Nation of Oklahoma; Prairie Band Potawatomi Nation; Seminole Tribe of Florida; Squaxin Island Tribe of the Squaxin Island Reservation; Suquamish Indian Tribe; Susanville Indian Rancheria; Swinomish Indian Tribal Community; and the Tonkawa Tribe of Indians of Oklahoma are federally-recognized tribes.

Amici National Indian Health Board; Affiliated Tribes of Northwest Indians; Alaska Native Health Board; All Indian Pueblo Council; Bristol Bay Area Health Corporation; Consolidated Tribal Health Project, Inc.; Council of Athabascan Tribal Governments; Great Plains Tribal Chairman's Association; Inter Tribal Council of Arizona, Inc.; Maniilaq Association; Montana-Wyoming Tribal Leaders Council; National Congress of American Indians; Northern Valley Indian Health, Inc.; Northwest Portland Area Indian Health Board; Norton Sound Health Corporation; and United South and Eastern Tribes, Inc. are tribal organizations[5] representing consortiums of federally-recognized tribes.

Amici tribes and tribal organizations have extensive knowledge of Indian health care policy and the implementation of federal laws related to Indian health care. *Amici* also have considerable experience with the history and operation of current health care laws, including the Indian Health Care Improvement Act ("IHCIA") and the legislative history of the reauthorization and amendment of the IHCIA enacted in Section 10221 of the ACA and other related Indian-specific provisions in the ACA.

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[5] A list of the member tribes of tribal organizations listed in this paragraph is attached in the Appendix.

Many of the *amici* tribes and tribal organizations have entered into agreements with the Secretary of Health and Human Services, acting through the Indian Health Service ("IHS"), pursuant to authority of the ISDEAA, 25 U.S.C. § 450 *et seq*., through which they provide health care services directly to Indian people in their geographic areas.

If this Court reaches the question of severability, the *amici* believe the brief will help the Court understand the severability question in a broader context framed by the unique history of the IHCIA and other Indian-specific provisions of the ACA.

ARGUMENT

The IHCIA amendments enacted in Section 10221 of the ACA and several other beneficial Indian provisions of the ACA have a separate genesis from the minimum coverage provision, are not connected to or dependent on the application of minimum coverage, and involve legally independent rights and obligations related solely to Indian tribes and their members, Indian people who are not members of tribes, and Indian health care providers. The IHCIA amendments were developed over a period of ten years in a separate legislative process from the ACA. In order to escape a legislative log jam, the Indian-specific provisions were put into the Senate's health care reform bill that became the ACA because it was a moving legislative vehicle. They were not part of or related to the minimum coverage component or other integral pieces of the general health care reform fabric.

Amici agree with the Court of Appeals' conclusion that the district court's "wholesale" invalidation of the ACA was improper. Based on a detailed review of the Act's provisions, the court concluded that the "lion's share" of the provisions of the ACA are "wholly unrelated" to minimum coverage and should remain intact. *Florida ex rel. Atty. Gen.*, 648 F.3d at 1322–23.[6]

Whatever this Court's conclusions are with respect to minimum coverage or other directly related provisions, the Indian provisions of the ACA present an *a fortiori* case and are separable even if the other provisions are not. First, it is highly significant that many of the Indian-specific provisions took effect and have been implemented already by IHS and the tribes, well ahead of the minimum coverage requirement, which does not take effect until 2014. And, as demonstrated below, the Indian-specific provisions can and do function independently "in a *manner* consistent with the intent of Congress." *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (emphasis in original).[7]

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[6] It is clear that the ACA is a package of many diverse provisions. Even a casual reading of the ACA demonstrates that Congress did not seek to achieve only one purpose in this massive law. The Court of Appeals' exhaustive review and catalog of the Act's provisions is summarized in Appendix A to the opinion. *See Florida ex rel. Atty. Gen.*, 648 F.3d at 1365–71.

[7] We note that the Attorney General for the State of Washington has acknowledged that IHCIA is severable from rest of the

We begin with a discussion of the history of Congress's involvement in Indian health care policy and describe the separate purposes and genesis of ACA Section 10221 incorporating the IHCIA amendments. We then discuss the other Indian-specific provisions in the ACA. Finally, we show that, consistent with governing severability rules, the Indian-specific provisions of the ACA are independent, freestanding laws that should remain intact even if this Court determines that the minimum coverage provision is unconstitutional.

I. Section 10221, reauthorizing and amending the IHCIA, is fully operative as law and is not related to and does not depend on the minimum coverage provision.

Originally enacted in 1976, the Indian Health Care Improvement Act is one of many distinct and specialized federal laws designed by Congress to address the unique needs of tribal communities and to carry out the Federal government's trust responsibility to Indians.[8] Since 1976, the IHCIA has functioned as the stand-alone statutory framework for the delivery

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ACA. Eleventh Circuit Opening/Response Brief of Appellee/Cross-Appellant States at 65 n. 8.

[8] The IHCIA and other Indian-specific provisions reflect the Federal government's trust responsibility and legal obligation to provide health care services to Indian tribes and Indian people. Articulated in treaties, judicial decisions, laws, regulations and policies over more than two centuries, the Federal trust responsibility to Indians has been repeatedly recognized by all branches of the Federal government. *See, e.g.*, President's Memorandum on Tribal Consultation, 74 Fed. Reg. 57,881 (Nov. 9, 2009), and Executive Order 13175 on Consultation and Coordination with Tribes, as guided by the trust relationship, 65 Fed. Reg. 67,249 (Nov. 6, 2000).

of health care services to Indian people, independent of any requirement that individual Indians obtain minimum coverage health insurance. For over ten years, *amici* tribes and tribal organizations worked with Congress to urge enactment of much needed improvements to the IHCIA. This effort resulted in the drafting of S. 1790, a separate and independent bill favorably reported by the Senate Committee on Indian Affairs. The IHCIA amendments had a separate legislative genesis from the process that produced the bulk of the ACA.

S. 1790, the IHCIA amendments legislation, was added as Section 10221 to H.R. 3590, the Senate's health care reform legislation, just two days before that bill which became the ACA was passed by the Senate. On December 22, 2009, the Senate adopted a Manager's package of amendments, one of which was a new Part III to Title X titled "Indian Health Care Improvement."[9] Part III consisted solely of Section 10221, a single page of legislation incorporating by reference over 260 pages of amendments to the IHCIA that originated as S. 1790, with four alterations to the text of that measure. H.R. 3590 as passed by the Senate on December 24, 2009, was adopted by the House of Representatives on March 21, 2010, and signed into law by the President on March 23, 2010 as Pub. L. No.111-148.

S. 1790, titled the "Indian Health Care Improvement Reauthorization and Extension Act of 2009", came out of a different committee than the remainder of the ACA, and has an entirely distinct legislative history. S. 1790 was introduced on October 15, 2009, by Senator Byron Dorgan and 15 co-sponsors; it was referred to the Senate Committee on Indian Affairs, the panel with primary jurisdiction over Indian health. By contrast, H.R. 3590 was the product of the Majority Leader's reconciliation of health care reform measures considered and approved by two other Senate committees—Finance and Health, Education, Labor and Pensions (HELP)—which have jurisdiction over all other health legislation. Amending the IHCIA was not a part of nor related to the efforts of those panels to craft health care reform bills.

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[9] S. Amdt. 3276: Roll Vote No. 387, 111th Cong., 155 CONG. REC. S13716 (daily ed. Dec. 22, 2009) and 155 CONG. REC. S13504 (daily ed. Dec. 19, 2009) (text of Amdt. 3276).

The separate genesis of the IHCIA reforms is consistent with Congress's separate and distinct treatment of Indian health care and the delivery of health care services to Indian people. The IHCIA was enacted in 1976 in response to the deplorable health status of Indian people, the shameful condition of the Indian hospitals and clinics, and inadequate or nonexistent sanitation facilities.[10] After reciting a catalog of the conditions which imperil Indian health, the new law made a firm commitment to Indian people in its Declaration of Policy:

> "The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian

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[10] The 94th Congress enacted the IHCIA to bring order and direction to the unsatisfactory manner in which Indian health care was then delivered by the Federal government. *See* H.R. REP. NO. 94-1026, pt. 1, at 1–17 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652–2657.

health services with all resources necessary to effect that policy."[11]

The IHCIA has been reauthorized and amended a number of times since 1976, with extensive substantive amendments enacted in 1992 to strengthen its programmatic provisions. In 1999, a new effort to reauthorize and update the IHCIA began. In that year and throughout the ensuing decade, IHCIA bills were introduced in every Congress. Some achieved congressional committee approval and one bill was debated on the Senate floor—the first time this occurred in more than 15 years.[12] But none of these bills was enacted.

Meanwhile, the health care crisis in Indian country continued. As Senator Dorgan observed in 2009 when introducing the seventh IHCIA Senate bill, "[w]e face a bona fide crisis in health care in our Native American communities, and this bill is a first step toward fulfilling our treaty obligations and trust responsibility to provide quality health care in Indian Country."[13] Despite improvement in some health status measures over prior decades, Indian health disparities continued to suggest comparisons with third world countries. Senator Dorgan cited to but a few of these: "Native Americans die of tuberculosis at a rate 600 percent higher than the general population, suicide rates are nearly double, alcoholism rates are

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[11] Indian Health Care Improvement Act, Pub. L. No. 94-437, Sec. 3, *reprinted in* 1976 U.S.C.C.A.N. (90 Stat. 1400).

[12] Indian Health Care Improvement Act Amendments of 2007, S. 1200: Roll Vote No. 32, 110th Cong., 154 CONG. REC. S1155 (daily ed. Feb. 26, 2008).

[13] 155 CONG. REC. S10493 (daily ed. Oct. 15, 2009).

510 percent higher, and diabetes rates are 189 percent higher than the general population."[14]

Attacking these health status deficiencies requires a sufficient level of resources, which the Indian health care system chronically lacks. When Congress enacted the IHCIA in 1976, it reported that per capita expenditures for Indian health were then "25 percent below per capita expenditures for health care in the average American community."[15] The problem of inadequate funding has not been cured in the years since 1976. The U.S. Commission on Civil Rights reported that for 2003, the IHS spending for Indian medical care was 62 percent lower than the U.S. per capita amount.[16] It also reported that the per capita amount spent on IHS medical care ($1,194) was only *half* the per capita amount spent on health care for Federal prisoners ($3,803), and at the bottom of the list of all federal health programs.[17] When introducing S. 1790 in the fall of 2009, Senator Dorgan observed that the health care system for Native Americans is "only funded at about half of its need."[18]

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[14] *Id.*

[15] H.R. REP. NO. 94-1026, pt. 1, at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2655.

[16] U.S. Comm'n on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, 98 (Sept. 2004), http://www.usccr.gov/pubs/nahealth/nabroken.pdf.

[17] *Id.* The other federal programs in the comparison were: Medicare ($5,915); Veterans Affairs users ($5,214); U.S. per capita ($5,065); Medicaid acute care ($3,879); and the Federal Employees Health Benefit program benchmark ($3,725). *Id.*

[18] 155 CONG. REC. S10493 (daily ed. Oct. 15, 2009) (statement of Sen. Dorgan).

The IHCIA revisions to the Indian health system address these long-standing concerns and are extremely important to Indian tribes. The amendments enacted by the ACA made the IHCIA a permanent Federal law without expiration date; enhanced authorities to recruit/retain health care professionals to overcome high vacancy rates; expanded programs to address diseases such as diabetes that are at alarmingly high levels in Indian country; augmented the ability of tribal epidemiology centers to devise strategies to address local health needs; provided more equitable and innovative procedures for construction of health care and sanitation facilities; expanded opportunities for third party collections in order to maximize all revenue sources; established comprehensive behavioral health initiatives, with a particular focus on the Indian youth suicide crisis; and expressly authorized operation of modern methods of health care delivery such as long-term care and home- and community-based care, staples of the mainstream health system but not previously specifically authorized for the Indian health system.

These critical amendments to the IHCIA are not related to and do not depend on the minimum coverage provision, nor has their constitutionality been questioned in any ACA litigation. They should remain intact.

II. Other ACA provisions intended to benefit Indian health and Indian people are not related to and do not depend on the minimum coverage provision.

Several other beneficial Indian provisions were also put into the Senate's health care reform bill:

- In Section 2901[19] Congress grouped into one section three unrelated subsections that benefit individual Indians or the Indian health system administered by tribes: (a) a cross-reference to the cost-sharing exemption for Indians enrolled in a qualified health plan offered through a state Exchange; (b) codification of payer of last resort status for the components of the Indian health provider system; and (c) designation of the IHS, tribes and tribal organizations that operate health programs, and urban Indian organizations as "express lane agencies" which, at the election of the state in which the program is located, are authorized to make Medicaid and CHIP eligibility determinations to facilitate enrollment of eligible individuals in those programs.

- Section 2902[20] amends Sec. 1880 of the Social Security Act, the statutory provision which authorizes IHS and tribally-operated hospitals and clinics to receive reimbursements from Medicare. Section 2902 removed the "sunset" date for collection of reimbursements for Medicare Part B services authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173).

- Section 3314[21] corrects a problem encountered by IHS, tribal and urban Indian organization pharmacies that provide Medicare Part D prescription drugs to their Indian patients without cost. Since the value of such drugs was not counted as out-of-pocket costs of the patient, the Indian patient was not able to qualify for the catastrophic coverage level under Part D. The Section 3314 amendment removed this barrier by directing that effective Jan. 1, 2011, the cost of drugs borne or paid by an Indian pharmacy are to be considered out-of-pocket costs of the patient.

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[19] These provisions were included in the health care reform bill reported by the Finance Committee and included in H.R. 3590 approved by the Senate. S. REP. NO. 111-89, at 105 (2009).

[20] This provision was included in the Finance Committee's health care reform bill reported to the Senate and was retained in H.R. 3590 as approved by the Senate. *Id.* at 106.

[21] This provision was added to the Finance Committee bill during mark-up, and was retained in the reconciled bill, H.R. 3590, approved by the Senate. *Id.* at 260.

- Section 9021[22] amends the Internal Revenue Code to exclude from an individual tribal member's gross income the value of health benefits, care or coverage provided by the IHS or by an Indian tribe or tribal organization to its members. The provision overrides the determination by the Internal Revenue Service that the value of health benefits purchased by an Indian tribe for its members constituted taxable income to the member even when a tribe stepped in to provide such coverage to compensate for insufficient funding from the IHS.

These Indian-specific provisions are not related to the minimum coverage provision and their constitutionality has not been challenged. Thus, like the IHCIA component of the ACA, they should remain in full force and effect.

III. The Indian–specific provisions of the ACA are "wholly unrelated" to minimum coverage and should remain intact.

The ACA's Indian-specific provisions make vital improvements to the Indian health care delivery system. None of the Indian-specific provisions described above is related to or dependent upon the efficacy or validity of the minimum coverage provision. In fact, members of Indian tribes are exempt from the penalty for failure to acquire minimum coverage. *See* 26 U.S.C. § 5000A(e)(3). This exemption reflects acknowledgement of the Federal government's trust responsibility for Indian health and is consistent with the Congressional practice of enacting the separate body of Indian-specific health care laws to carry out that responsibility.

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[22] This provision was added to the Finance Committee's health care reform bill that was reported to the Senate and was retained in the reconciled bill, H.R. 3590, approved by the Senate. *Id.* at 356.

The Indian health care delivery system is distinct from the mainstream health care system. It was established by the Federal government to carry out a Federal responsibility to the indigenous people who, without the IHS system, would not have meaningful access to health services. IHS health care facilities are located in Indian communities. IHS programs are tailored to address the needs of those communities. IHS personnel are responsible for directly providing care unless a tribe elects to take over operation of health programs under the ISDEAA and the IHCIA, as many have done.

Unlike the mainstream health delivery system for which the minimum coverage and guaranteed-issue insurance reforms were created, the Indian health system is not insurance-based. Rather, it is designed specifically to perform the Federal trust responsibility for Indian health, and the IHCIA directs how this Federal responsibility is to be carried out. Services to Indian people are provided directly at IHS and tribal hospitals and clinics, supplemented by the purchase of contract health services when such hospitals and clinics are unable to provide them. While these Indian programs are authorized to collect reimbursements from Medicare, Medicaid and private insurance when they serve Indian patients with such coverage, enrollment in an insurance plan is not a pre-requisite for receiving IHS care. Eligibility for IHCIA-authorized programs is defined in Federal regulations based on Indian status and is not dependent on obtaining health insurance.

These laws were enacted to carry out treaty and other land-cession obligations assumed by the United States. They have evolved as programs designed to implement the federal trust responsibility to provide health care to Indians and enhance tribal self-determination and self-governance, while providing tools for tribes to increase the quality and quantity of governmental services, including health care services, to Indian people. *See generally Cohen's Handbook of Federal Indian Law* §§ 22.01[1] - 22.01[3] ("Obligation to Provide Services") (2005 ed.).[23]

Neither the district court nor the Eleventh Circuit Court of Appeals analyzed the Indian-specific ACA provisions, and therefore did not make any factual findings that distinguish them from the minimum coverage requirement and related insurance industry reforms. If such analyses were performed, however, application of the Supreme Court's severability rules would demonstrate that the Indian-specific provisions are among the ACA provisions that are "wholly unrelated" to minimum coverage. *See Florida ex rel. Atty. Gen.*, 648 F.3d at 1322–23.

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[23] Adopted initially in 1976, the IHCIA, 25 U.S.C. § 1601 *et seq.*, has been amended several times as described above. Congress has repeatedly enacted broad legislation to facilitate tribal control of Federal programs for Indians, including the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450 *et seq.* (authorizing tribes to contract and control federal programs); Tribally Controlled Schools Act, 25 U.S.C. § 2501 *et seq.* (education); Native American Housing Assistance and Self-Determination Act, 25 U.S.C. § 4101 *et seq.* (housing); Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. § 3401 *et seq.* (employment and work training); Indian Child Welfare Act, 25 U.S.C. § 1901 *et seq.* (adoption and child welfare). The Supreme Court has long recognized the "distinctive obligation of trust incumbent upon the Government" in its dealings with tribes. *See Seminole Nation v. United States*, 316 U.S. 286, 296 (1942).

As this Court recently stated: "Generally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact." *Free Enterprise Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3161 (2010) (citations and internal quotation marks omitted). A court should "strive to salvage" as much as possible of a statute, so that the court does not "use its remedial powers to circumvent the intent of the legislature." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329–30 (2006) (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979)). "Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *See Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999) (applying severability principles to executive order) (quoting *Champlin Refining Co. v. Corporation Comm'n of Okla.*, 286 U.S. 210, 234 (1932)).[24]

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[24] Since respect for Congress's purpose and intent requires careful analysis to determine whether a particular provision of a statute is unconstitutional, it stands to reason that the remaining portions of the statute, presumed valid, should also be scrutinized carefully to determine if they are independent provi-

After careful review of the entire ACA, the Eleventh Circuit Court of Appeals reversed the district court's "wholesale" invalidation of the Act. The court concluded that "[i]n light of the stand-alone nature of hundreds of the Act's provisions and their manifest lack of connection" to minimum coverage, the district court "erred in its wholesale invalidation of the Act." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1323.[25]

As summarized by the Court of Appeals, this Court has eschewed wholesale invalidation of statutes. "In the overwhelming majority of cases, the Supreme Court has opted to sever the constitutionally defective provision from the remainder of the statute." *Florida ex rel. Atty. Gen.*, 648 F.3d at 1321, *citing*, *inter alia*, *Free Enterprise Fund*, 130 S. Ct. at 3161–62.[26]

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sions of law and therefore remain valid. "[A]n Act of Congress ought not to be construed to violate the Constitution if any other possible construction remains available." *NLRB v. Catholic Bishop of Chicago*, 440 U.S. 490, 500 (1979).

[25] The Court of Appeals also ruled that lack of a severability clause in the ACA did not require invalidation of the statute in its entirety, even though a severability clause was included in an earlier version of the legislation but dropped from the version of the bill enacted into law. The presence or absence of a severability clause may inform review, but it is still necessary to analyze whether Congress would have enacted each provision of the statute even when a clause is included in the statute. *See Alaska Airlines*, 480 U.S. at 686.

[26] In no recent case has the Court questioned the validity of a statute in its entirety without engaging in or requiring an analysis of the relationship between an unconstitutional provision and the remainder of the statute's provisions. *See Randall v. Sorrell*, 548 U.S. 230, 262 (2006), where the Court did strike the entire law, but only after reviewing the entire law and concluding that saving it would have required the Court to, among other things, "write words into the statute." *See also*

If this Court declares the minimum coverage provision unconstitutional, there may be a legitimate question whether it is integral to implementation of certain other provisions included in the ACA.[27] But there can be no question about the fact that the IHCIA and other Indian-specific provisions are separate and distinct from the controversial minimum coverage provision and related insurance industry reforms included in the ACA.

Simply put, the IHCIA and other Indian-specific provisions can and do function independently "in a *manner* consistent with the intent of Congress," *Alaska Airlines*, 480 U.S. at 685 (emphasis in original), and those provisions should remain intact even if the minimum coverage provision is held unconstitutional and severed.

Ayotte, 546 U.S. at 328–31 (holding that invalidating the New Hampshire Parental Notification Prior to Abortion Act in its entirely may not be justified and remanding to lower courts to determine if narrower relief was possible).

[27] For example, the courts have divided on the question whether insurance industry reforms such as guaranteed issue and pre-existing conditions must be severed along with the minimum coverage provision. The Court of Appeals in this case reviewed those provisions and allowed them to stand. *See Florida ex rel. Atty. Gen.*, 648 F.3d at 1323–1328. In *Goudy-Bachman v. United States Department of Health and Human Services*, __ F. Supp. 2d __, 2011 WL 4072875 (M.D. Pa. Sept. 13, 2011), the court severed those same two market reform provisions. The United States argues that the Act's guaranteed-issue and community-rating insurance industry reforms must be severed if the minimum coverage provision is stricken. *See* United States' Consolidated Brief for Respondents at 10.

CONCLUSION

If this Court affirms the ruling by the Eleventh Circuit Court of Appeals that the minimum coverage provision is unconstitutional, we respectfully request that the Court also uphold the Circuit Court's ruling that the remaining provisions of the Act are severable and remain valid, at least with respect to the IHCIA and other Indian-specific provisions, which are clearly separable and fully operative as law, and are intended to carry out the well-established special obligations of the United States to Indians.

Respectfully submitted,

GEOFFREY D. STROMMER *
CAROL L. BARBERO
VERNON L. PETERSON
ELLIOTT MILHOLLIN
WILLIAM R. NORMAN
JESSICA M. WILES
HOBBS, STRAUS, DEAN &
WALKER, LLP
806 SW Broadway, Suite 900
Portland, Oregon 97205
(503) 242-1745
GStrommer@hobbsstraus.com

* Counsel of Record

January 27, 2012

APPENDIX

APPENDIX

LIST OF MEMBER TRIBES OF *AMICI* TRIBAL ORGANIZATIONS

Affiliated Tribes of Northwest Indians (AK, WA, OR, ID, CA, MT, NV)

Organized Village of Kasaan, Alaska

Central Council of the Tlingit & Haida Indian Tribes, Alaska

Hoopa Valley Tribe, California

Karuk Tribe, California

Blackfeet Tribe of the Blackfeet Indian Reservation of Montana

Chippewa-Cree Indians of the Rocky Boy's Reservation, Montana

Confederated Salish & Kootenai Tribes of the Flathead Reservation, Montana

Shoshone-Paiute Tribes of the Duck Valley Reservation, Nevada

Summit Lake Paiute Tribe of the Duck Valley Reservation, Nevada

Chinook Tribe, Washington

Duwamish Tribe, Washington

Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon

Confederated Tribes of the Chehalis Reservation, Washington

Coeur D'Alene Tribe of the Coeur D'Alene Reservation, Idaho

Confederated Tribes of the Colville Reservation, Washington

Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon

Coquille Tribe of Oregon

Cow Creek Band of Umpqua Indians of Oregon

Cowlitz Indian Tribe, Washington

Confederated Tribes of the Grand Ronde Community of Oregon

Hoh Indian Tribe of the Hoh Indian Reservation, Washington

Jamestown S'Klallam Tribe of Washington

Kalispel Indian Community of the Kalispel Reservation, Washington

Klamath Tribes, Oregon

Kootenai Tribe of Idaho

Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington

Lummi Tribe of the Lummi Reservation, Washington

Makah Indian Tribe of the Makah Indian Reservation, Washington

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington

Nez Perce Tribe, Idaho

Nisqually Indian Tribe of the Nisqually Reservation, Washington

Nooksack Indian Tribe of Washington

Northwestern Band of Shoshone Nation of Utah (Washakie)

Port Gamble Indian Community of the Port Gamble Reservation, Washington

Puyallup Tribe of the Puyallup Reservation, Washington

Quileute Tribe of the Quileute Reservation, Washington

Quinault Tribe of the Quinault Reservation, Washington

Samish Indian Tribe, Washington

Sauk-Suiattle Indian Tribe of Washington

Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation, Washington

Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho

Confederated Tribes of Siletz Indians of Oregon

Skokomish Indian Tribe of the Skokomish Reservation, Washington

Snoqualmie Tribe, Washington

Snohomish Tribe, Washington

Spokane Tribe of the Spokane Reservation, Washington

Squaxin Island Tribe of the Squaxin Island Reservation, Washington

Steilacoom Tribe, Washington

Stillaguamish Tribe of Washington

Suquamish Indian Tribe of the Port Madison Reservation, Washington

Swinomish Indian Tribal Community, Washington

Tulalip Tribes of the Tulalip Reservation, Washington

Confederated Tribes of the Umatilla Reservation, Oregon

Upper Skagit Indian Tribe of Washington

Confederated Tribes of the Warm Springs Reservation of Oregon

Confederated Tribes and Bands of the Yakama Nation, Washington

Alaska Native Health Board (AK)

Aleutian Pribilof Islands Association Inc., whose member tribes include:

Native Village of Akutan

Native Village of Atka

Native Village of Belkofski

Native Village of False Pass

Agdaagux Tribe of King Cove

Native Village of Nelson Lagoon

Native Village of Nikolski

Pauloff Harbor Village

Qagan Tayagungin Tribe of Sand Point Village

Saint George Island

Saint Paul Island

Qawalangin Tribe of Unalaska

Native Village of Unga

Arctic Slope Native Association Inc., whose member tribes include:

- Native Village of Barrow
- Naqsragmiut Tribal Council
- Atqasuk Village
- Kaktovik Village
- Native Village of Nuiqsut
- Native Village of Point Hope
- Native Village of Point Lay
- Village of Wainwright

Bristol Bay Area Health Corporation, whose member tribes are listed separately below

Chugachmiut, whose member tribes include:

- Chenega IRA
- Native Village of Eyak
- Nanwalek IRA
- Port Graham Village
- Qutekcak Native Tribe
- Tatitlek IRA
- Valdez Native Tribe

Copper River Native Association, whose member tribes include:

- Gulkana Village
- Native Village of Gakona
- Cheesh-Na Tribe
- Native Village of Chitina

Native Village of Kluti-Kaah (Copper Center)

Native Village of Tazlina

Council of Athabascan Tribal Governments, whose member tribes are listed separately below

Eastern Aleutian Tribes, whose member tribes include:

Agdaagux Tribe of King Cove

Native Village of Akutan

Native Village of Nelson Lagoon

Native Village of Unga

Qagan Tayagungin Tribe of Sand Point Village

Native Village of False Pass

Pauloff Harbor Village

Kodiak Area Native Association, whose member tribes include:

Native Village of Akhiok

Native Village of Karluk

Village of Old Harbor

Native Village of Ouzinkie

Native Village of Port Lions

Native Village of Larsen Bay

Maniilaq Association, whose member tribes are listed separately below

Metlakatla Indian Community

Mt. Sanford Tribal Consortium, whose member tribes include:

Mentasta Traditional Council

Cheesh-Na Tribe

Native Village of Eklutna

Native Village of Tyonek

Ninilchik Village Traditional Council

Norton Sound Health Corporation, whose member tribes are listed separately below

Seldovia Village Tribe

Southcentral Foundation

Southeast Alaska Regional Health Consortium, whose member tribes include:

Angoon Community Association

Chilkoot Indian Association

Craig Community Association

Douglas Indian Association

Hoonah Indian Association

Hydaburg Cooperative Association

T&H Indians of the City & Borough of Juneau

Organized Village of Kake

Organized Village of Kasaan

Klawock Cooperative Association

Chilkat Indian Village

Pelican T&H Community Council

Petersburg Indian Association

Sitka Tribe of Alaska

Skagway Traditional Council

Tenakee Springs Indian Community

Wrangell Cooperative Association

Yakutat Tlingít Tribe

Tanana Chiefs Conference, whose member tribes include:

Alatna Traditional Council

Allakaket Traditional Council

Evansville Tribal Council

Hughes Traditional Council

Lake Minchumina Traditional Council

Manley Hot Springs Traditional Council

Minto Traditional Council

Nenana Traditional Council

Rampart Traditional Council

Stevens Village IRA Council

Tanana Tribal Council

Arctic Village Traditional Council

Beaver Traditional Council

Birch Creek Tribal Council

Canyon Village Traditional Council

Chalkyitsik Traditional Council

Circle Traditional Council

Gwichyaa Zhee Gwich'in Tribal Gov

Venetie Traditional Council

Dot Lake Village Council

Eagle IRA Council

Healy Lake Traditional Council

Northway Traditional Council

Tanacross IRA Council

Tetlin IRA Council

Tok Native Association

Galena Village (aka Louden Village)

Huslia Traditional Council

Kaltag Traditional Council

Koyukuk Traditional Council

Nulato Tribal Council

Ruby Tribal Council

McGrath Traditional Council

Medfra Traditional Council

Edzeno Native Council

Takotna Traditional Council

Telida Native Village Council

Anvik Traditional Council

Grayling IRA Council

Holy Cross Traditional Council

Shageluk IRA Council

Yukon Kuskokwim Health Corporation, whose member tribes include:

Akiachak Native Community

Akiak Native Community

Village of Alakanuk

Village of Aniak

Anvik Traditional Council

Village of Atmautluak
Orutsararmuit Native Village (aka Bethel)
Village of Chefornak
Chevak Native Village
Native Village of Chuathbaluk
Village of Crooked Creek
Native Village of Eek
Emmonak Village
Grayling IRA Council
Holy Cross Village
Native Village of Hooper Bay
Kasigluk Traditional Elders Council
Native Village of Kipnuk
Native Village of Kongiganak
Village of Kotlik
Organized Village of Kwethluk
Native Village of Kwigillingok
Lime Village
Village of Lower Kalskag
Native Village of Marshall
Native Village of Mekoryuk
Mt. Village
Native Village of Napakiak
Native Village of Napaskiak
Newtok Village

Native Village of Nightmute

Native Village of Nunam Iqua

Native Village of Nunapitchuk

Oscarville Traditional Village

Pilot Station Traditional Village

Native Village of Pitka's Point

Native Village of Kwinhagak (aka Quinhagak)

Village of Red Devil

Native Village of Chuathbaluk (Russian Mission, Kuskokwim)

Native Village of Scammon Bay

Shageluk Native Village

Village of Sleetmute

Algaaciq Native Village (St. Mary's)

Village of Stony River

Toksook Bay

Tuluksak Native Community

Native Village of Tuntutuliak

Native Village of Tununak

Village of Kalskag (Upper Kalskag)

Valdez Native Tribe

All Indian Pueblo Council (NM, TX)

Pueblo of Acoma, New Mexico

Pueblo of Cochiti, New Mexico

Pueblo of Isleta, New Mexico

Pueblo of Jemez, New Mexico

Pueblo of Laguna, New Mexico
Pueblo of Nambe, New Mexico
Ohkay Owingeh, New Mexico
Pueblo of Picuris, New Mexico
Pueblo of Pojoaque, New Mexico
Pueblo of Sandia, New Mexico
Pueblo of Santa Ana, New Mexico
Pueblo of Santa Clara, New Mexico
Pueblo of San Felipe, New Mexico
Pueblo of San Ildefonso, New Mexico
Pueblo of Santo Domingo, New Mexico
Pueblo of Taos, New Mexico
Pueblo of Tesuque, New Mexico
Pueblo of Zia, New Mexico
Pueblo of Ysleta del Sur, Texas
Pueblo of Zuni, New Mexico

Bristol Bay Area Health Corporation (AK)

Portage Creek Village (aka Ohgsenakale)
Ekwok Village
New Stuyahok Village
New Koliganek Village Council
Dillingham (Curyung Tribal Council)
Native Village of Aleknagik
Village of Clarks Point
Native Village of Ekuk

Knugank Tribal Council
Chignik Bay Tribal Council
Native Village of Chignik Lagoon
Chignik Lake Village
Native Village of Perryville
Ivanof Bay Village
Manokotak Village
Twin Hills Village
Traditional Village of Togiak
Native Village of Goodnews Bay
Platinum Traditional Village
Ugashik Village
Native Village of Pilot Point
Egegik Village
Naknek Native Village
South Naknek Village
Levelock Village
King Salmon Tribe
Native Village of Port Heiden
Native Village of Kanatak
Nondalton Village
Village of Iliamna
Pedro Bay Village
Kokhanok Village
NewhalenVillage

Igiugig Village

Consolidated Tribal Health Project, Inc. (CA)

Cahto Indian Tribe of the Laytonville Rancheria

Coyote Valley Band of Pomo Indians of California

Guidiville Rancheria of California

Hopland Band of Pomo Indians of the Hopland Rancheria

Pinoleville Pomo Nation

Potter Valley Tribe

Redwood Valley Rancheria of Pomo Indians of California

Sherwood Valley Rancheria of Pomo Indians of California

Council of Athabascan Tribal Governments (AK)

Arctic Village (Native Village of Venetie Tribal Government)

Beaver Village

Birch Creek Tribe

Canyon Village

Chalkyitsik Village

Circle Native Community

Native Village of Fort Yukon

Rampart Village

Native Village of Stevens

Village of Venetie (Native Village of Venetie Tribal Government)

Great Plains Tribal Chairman's Association (ND, SD, NE)

Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota

Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota

Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota

Yankton Sioux Tribe of South Dakota

Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota

Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, South Dakota

Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota

Flandreau Santee Sioux Tribe of South Dakota

Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota

Standing Rock Sioux Tribe of North & South Dakota

Turtle Mountain Band of Chippewa Indians of North Dakota

Spirit Lake Tribe, North Dakota

Omaha Tribe of Nebraska

Ponca Tribe of Nebraska

Santee Sioux Nation, Nebraska

Winnebago Tribe of Nebraska

Inter Tribal Council of Arizona, Inc. (AZ)

- Ak-Chin Indian Community
- Cocopah Indian Tribe
- Colorado River Indian Tribes
- Fort McDowell Yavapai Nation
- Fort Mojave Indian Tribe
- Gila River Indian Community
- Havasupai Tribe
- Hopi Tribe
- Hualapai Tribe
- Kaibab-Paiute Tribe
- Pascua Yaqui Tribe
- Pueblo of Zuni
- Quechan Tribe
- Salt River Pima-Maricopa Indian Community
- San Carlos Apache Tribe
- Tohono O'odham Nation
- Tonto Apache Tribe
- White Mountain Apache Tribe
- Yavapai Apache Nation
- Yavapai Prescott Indian Tribe

Maniilaq Association (AK)

- Native Village of Ambler
- Native Village of Buckland
- Native Village of Kiana

Native Village of Kivalina

Native Village of Kobuk

Native Village of Kotzebue

Native Village of Noatak

Noorvik Native Community

Native Village of Point Hope

Native Village of Selawik

Native Village of Shungnak

Montana-Wyoming Tribal Leaders Council (ID, MT, WY)

Arapaho Tribe of the Wind River Reservation, Wyoming

Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana

Blackfeet Tribe of the Blackfeet Indian Reservation of Montana

Chippewa-Cree Indians of the Rocky Boy's Reservation, Montana

Confederated Salish & Kootenai Tribes of the Flathead Reservation, Montana

Crow Tribe of Montana

Eastern Shoshone Tribe, Wyoming

Fort Belknap Indian Community of the Fort Belknap Reservation of Montana

Little Shell Tribe of Chippewa Indians of Montana

Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana

Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho

Northern Valley Indian Health, Inc. (CA)

Grindstone Indian Rancheria of Wintun-Wilacki Indians

Mechoopda Indian Tribe of Chico Rancheria

Northwest Portland Area Indian Health Board (WA, OR, ID, UT)

Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon

Confederated Tribes of the Chehalis Reservation, Washington

Coeur D'Alene Tribe of the Coeur D'Alene Reservation, Idaho

Confederated Tribes of the Colville Reservation, Washington

Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon

Coquille Tribe of Oregon

Cow Creek Band of Umpqua Indians of Oregon

Cowlitz Indian Tribe, Washington

Confederated Tribes of the Grand Ronde Community of Oregon

Hoh Indian Tribe of the Hoh Indian Reservation, Washington

Jamestown S'Klallam Tribe of Washington

Kalispel Indian Community of the Kalispel Reservation, Washington

Klamath Tribes, Oregon

Kootenai Tribe of Idaho

Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington

Lummi Tribe of the Lummi Reservation, Washington

Makah Indian Tribe of the Makah Indian Reservation, Washington

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington

Nez Perce Tribe, Idaho

Nisqually Indian Tribe of the Nisqually Reservation, Washington

Nooksack Indian Tribe of Washington

Northwestern Band of Shoshone Nation of Utah (Washakie)

Port Gamble Indian Community of the Port Gamble Reservation, Washington

Puyallup Tribe of the Puyallup Reservation, Washington

Quileute Tribe of the Quileute Reservation, Washington

Quinault Tribe of the Quinault Reservation, Washington

Samish Indian Tribe, Washington

Sauk-Suiattle Indian Tribe of Washington

Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation, Washington

Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho

Confederated Tribes of the Siletz Indians of Oregon

Skokomish Indian Tribe of the Skokomish Reservation, Washington

Snoqualmie Tribe, Washington

Spokane Tribe of the Spokane Reservation, Washington

Squaxin Island Tribe of the Squaxin Island Reservation, Washington

Stillaguamish Tribe of Washington

Suquamish Indian Tribe of the Port Madison Reservation, Washington

Swinomish Indian Tribal Community, Washington

Tulalip Tribes of the Tulalip Reservation, Washington

Confederated Tribes of the Umatilla Reservation, Oregon

Upper Skagit Indian Tribe of Washington

Confederated Tribes of the Warm Springs Reservation of Oregon

Confederated Tribes and Bands of the Yakama Nation, Washington

Norton Sound Health Corporation (AK)

Native Village of Brevig Mission

Native Village of Council

Native Village of Diomede

Native Village of Elim

Native Village of Gambell

Chinik Eskimo Community (Golovin)

King Island Native Community

Native Village of Koyuk

Native Village of Mary's Igloo

Nome Eskimo Community

Native Village of St. Michael

Native Village of Savoonga

Native Village of Shaktoolik

Native Village of Shishmaref

Village of Solomon

Stebbins Community Association

Native Village of Teller

Native Village of Unalakleet

Native Village of Wales

Native Village of White Mountain

United South and Eastern Tribes, Inc. (ME, NY, MA, MS, NC, NY, FL, SC, LA, AL, RI, CT, TX)

Eastern Band of Cherokee Indians, North Carolina

Miccosukee Tribe of Indians of Florida

Mississippi Band of Choctaw Indians

Seminole Tribe of Florida

Chitimacha Tribe of Louisiana

Seneca Nation of Indians, New York

Coushatta Tribe of Louisiana

Saint Regis Mohawk Tribe, New York

Penobscot Indian Nation, Maine

Passamaquoddy Tribe—Pleasant Point, Maine

Passamaquoddy Tribe—Indian Township, Maine

Houlton Band of Maliseet Indians, Maine

Tunica-Biloxi Tribe of Louisiana

Poarch Band of Creek Indians, Alabama

Narragansett Indian Tribe, Rhode Island

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Catawba Indian Nation, South Carolina

Jena Band of Choctaw Indians, Louisiana

The Mohegan Tribe, Connecticut

Cayuga Nation, New York

Mashpee Wampanoag Tribe, Massachusetts

Shinnecock Indian Nation, New York

AMICUS
CURIAE
BRIEF

No. 11-400

In The
Supreme Court of the United States

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STATE OF FLORIDA, ET AL., PETITIONERS,

v.

DEPARTMENT OF HEALTH AND
HUMAN SERVICES, ET AL.

◆

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

◆

BRIEF FOR NATIONAL MINORITY AIDS COUNCIL; AMFAR, THE FOUNDATION FOR AIDS RESEARCH; HIV MEDICINE ASSOCIATION; NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS; AND TREATMENT ACCESS EXPANSION PROJECT AS AMICI CURIAE SUPPORTING RESPONDENTS

(Medicaid)

◆

DEANNE E. MAYNARD
MARC A. HEARRON*
MORRISON & FOERSTER LLP
2000 Pennsylvania Ave., N.W.
Washington, D.C. 20006
mhearron@mofo.com
202.778.1663

**Counsel of Record*

Counsel for Amici Curiae

FEBRUARY 17, 2012

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BRIEF FOR NATIONAL MINORITY AIDS COUNCIL; AMFAR, THE FOUNDATION FOR AIDS RESEARCH; HIV MEDICINE ASSOCIATION; NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS; AND TREATMENT ACCESS EXPANSION PROJECT AS AMICI CURIAE SUPPORTING RESPONDENTS

The National Minority AIDS Council; amfAR, The Foundation for AIDS Research; the HIV Medicine Association; the National Alliance of State & Territorial AIDS Directors; and the Treatment Access Expansion Project respectfully submit this brief as amici curiae in support of respondents.[1]

INTEREST OF AMICI CURIAE

The **National Minority AIDS Council (NMAC)** is a nonprofit organization with the mission to develop leadership in communities of color to end the HIV/AIDS epidemic. Since its founding in 1987, NMAC has advanced this mission through a variety of public policy education programs, national conferences, treatment and research programs and trainings, electronic and printed resource materials, and through its website. NMAC represents a coalition of close to 3,000 faith- and community-based and AIDS service organizations that deliver HIV/AIDS services in communities of color nationwide.

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[1] Letters providing blanket consent to the filing of amicus briefs have been filed with the Clerk of the Court, pursuant to Rule 37.3(a). No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than amici curiae, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

amfAR, The Foundation for AIDS Research, is one of the world's leading nonprofit organizations dedicated to the support of HIV/AIDS research, prevention, treatment education, and advocacy for evidence-based AIDS-related public policy. amfAR identifies critical gaps in our knowledge of HIV/AIDS, and supports promising early-stage studies that often lack the preliminary data required by more traditional funders. amfAR also strives to reduce worldwide rates of HIV infection in low- and middle-income countries by providing small grants to grassroots groups that help expand HIV education and prevention. amfAR aims to generate awareness of the need for better treatment and prevention methods, and publishes educational materials on important AIDS-related research, treatment, prevention, and policy issues.

The **HIV Medicine Association (HIVMA)** is a national organization representing more than 4,800 HIV medical providers, researchers, and scientists working in all 50 States and more than 50 countries. HIVMA is nested within the Infectious Diseases Society of America and was created in 2001 to promote access to quality HIV care and to advocate for federal policies that ensure a comprehensive and humane response to the AIDS pandemic, informed by science and social justice. As an organization representing frontline medical providers caring for many uninsured and underinsured patients with HIV/AIDS, HIVMA has a strong interest in supporting sound healthcare financing policies that improve access to lifesaving care and treatment for people living with HIV/AIDS.

The **National Alliance of State and Territorial AIDS Directors (NASTAD)** represents the Nation's chief state health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis healthcare, prevention, education, and supportive service programs funded by state and federal governments. NASTAD is dedicated to reducing the incidence of HIV/AIDS and viral hepatitis infections in the United States and its territories, providing comprehensive, compassionate, and high-quality care to all persons living with HIV/AIDS and viral hepatitis, and ensuring responsible public policies. NASTAD provides national leadership to achieve these goals, and to educate about and advocate for the necessary federal funding to achieve them, as well as to promote communication between state and local health departments and HIV/AIDS and viral hepatitis care and treatment programs. NASTAD supports and encourages the use of applied scientific knowledge and input from affected communities to guide the development of effective policies and programs.

Based in Washington, D.C. and Boston, Massachusetts, the **Treatment Access Expansion Project (TAEP)** is a national organization that has worked since 1996 to improve access to affordable, comprehensive, high-quality health care for poor and low-income people living with chronic medical conditions, including HIV/AIDS. TAEP plays a leadership role within the HIV/AIDS community in addressing emerging healthcare opportunities and challenges by coordinating and informing efforts of national, state, and local partners to expand access to care. TAEP specifically focuses on four goals: supporting HIV testing and linkage to care initiatives, reducing the number of people diagnosed late in their disease progression, promoting early access to care and treatment, and eliminating HIV-related stigma and discrimination. TAEP has been integrally involved in shaping and carrying out the national HIV/AIDS community's advocacy efforts related to healthcare reform and the Patient Protection and Affordable Care Act.

Amici have a strong interest in making treatment available for all persons living with HIV/AIDS. Nearly half of all persons living with HIV in the United States who are receiving regular care are enrolled in Medicaid. But because of Medicaid's eligibility requirements, most uninsured low-income adults with HIV are ineligible and therefore lack access to the recommended antiretroviral therapy. The Medicaid expansion provisions of the Patient Protection and Affordable Care Act will make critical treatment available to many more low-income adults living with HIV/AIDS.

Amici submit this brief to demonstrate the real-world implications of the Affordable Care Act's Medicaid expansion provisions, not only on quality of life for low-income Americans, but also on ending the HIV/AIDS epidemic.

INTRODUCTION AND SUMMARY OF ARGUMENT

Under Medicaid law before the Patient Protection and Affordable Care Act, most low-income adults living with HIV do not qualify for Medicaid, even if they meet Medicaid's income limitations. That is because, to be eligible for Medicaid, a person must not only have income below a certain level, the person also must fall into one of several categories. Most non-disabled adults without dependent children are categorically excluded from Medicaid enrollment.

Disability is by far the most common category through which uninsured adults with HIV qualify for Medicaid. But the disability requirement sets a cruel trap. The standard of care for individuals with HIV is a regimen of highly active antiretroviral treatments, which successfully suppresses the progression of the virus and staves off disability. But most low-income individuals with HIV are unable to access the treatment regimen through Medicaid. That is because HIV infection, alone, is not a qualifying disability for Medicaid eligibility. Only once an individual's HIV has progressed to the point that he or she is unable to work or is diagnosed with AIDS does the individual qualify for Medicaid and for the very treatment that could have prevented disability in the first place.

The Affordable Care Act removes the disability requirement and makes Medicaid available to all adults who earn up to 133% of the federal poverty level. That means that all income-eligible individuals living with HIV will have access to essential antiretroviral treatments.

The Medicaid expansion will have tremendous results in the fight against the HIV/AIDS epidemic. It will prolong life potentially by decades for literally hundreds of thousands of persons. It will also substantially improve quality of life for those who receive treatment. For most individuals with HIV who are on an antiretroviral treatment regimen, HIV is a chronic but manageable disease. Individuals can continue to work and go about their daily lives as productive members of society and can continue contributing to the U.S. economy.

Just as important, the Medicaid expansion has the potential to slow dramatically the spread of HIV infection in the overall population. Studies of places where HIV/AIDS treatment has been made universally available have shown transmission rates cut *in half*. HIV treatment can suppress the presence of the virus in the bloodstream to an extremely low—often undetectable—level, and thereby sharply reduce the chances of transmission. Epidemiologists have concluded that increased availability of antiretroviral treatment, combined with better health education and HIV screening, will successfully slow the spread of the disease.

Although the costs of care are substantial, treatment is very cost-effective. Better early treatment means less direct spending on acute and hospice care. Decreased transmission rates mean less spending later on HIV/AIDS treatment. Earlier treatment means that individuals can stay productive for much longer during their working years. And that means less spending on other state services.

The judgment of the Eleventh Circuit upholding the Medicaid expansion provisions of the Affordable Care Act should be affirmed.

ARGUMENT

THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION PROVISION WILL REDUCE HIV TRANSMISSION, IMPROVE QUALITY OF LIFE, AND PREVENT DEATHS, AND IT WILL DO SO COST-EFFECTIVELY

The Affordable Care Act's Medicaid expansion provisions will remove the single largest obstacle that keeps uninsured adults with HIV/AIDS who earn up to 133% of the federal poverty level from receiving treatment through Medicaid. That will be a critical step toward not only improving public health but ending the HIV/AIDS epidemic.

A. The Disability Requirement In Current Medicaid Law Makes Highly Effective HIV Treatment Unavailable For Most Uninsured Low-Income Adults

Under Medicaid law before the Affordable Care Act, most non-disabled low-income adults without dependent children are categorically excluded from qualifying for Medicaid enrollment. That is because having income below a certain level does not, alone, make someone eligible for Medicaid. In addition to the income requirement, persons also must fall into one of several categories enumerated by statute. 42 U.S.C. § 1396a(a)(10)(A)(i). Those categories include children, parents with dependent children, pregnant women, and persons who receive Supplemental Security Income benefits due to a disability. 42 U.S.C. § 1396a(a)(10)(A)(i)(II), (III); *id.* § 1396d(a).

For persons living with HIV/AIDS, disability is by far the most common categorical eligibility pathway to qualify for Medicaid. Jen Kates, ***Medicaid and HIV: A National Analysis,*** KAISER FAMILY FOUNDATION at 1 (Sep. 30, 2011), http://www.kff.org/hivaids/8218.cfm. Seventy-four percent of persons living with HIV/AIDS who are enrolled in Medicaid qualify because of disability. *Id.* at 1, 17. Disability is the most likely eligibility pathway because individuals with HIV are more likely to be male and less likely to have dependent children than the overall population. *Id.* at 8. In contrast, only about a fifth of Medicaid enrollees who do not have HIV qualify on the basis of a disability. *Id.* at 1, 17. Although many participating States have expanded Medicaid eligibility beyond the federal minimums, the expansions primarily benefit children. Thus, for non-disabled adults, Medicaid eligibility is very limited. *Id.* at 4.

Yet having HIV—the virus that causes AIDS—is not considered a disability for Medicaid eligibility purposes. *Id.* at 4. Persons may live with HIV—and may even be completely asymptomatic—for many years before they develop AIDS. Centers for Disease Control and Prevention, *Living with HIV/AIDS* (Jun. 21, 2007), http://www.cdc.gov/hiv/resources/brochures/livingwithhiv.htm [hereinafter CDC, *Living with HIV/AIDS*]. Persons with HIV qualify as disabled only once their disease progresses to the point that they are no longer able to work or when they are diagnosed with AIDS. Kates, *supra*, at 4.

But having to wait for Medicaid coverage until HIV progresses to AIDS deprives persons with HIV of the very care that might prevent that progression. The current recommended treatment for HIV involves a combination of three or more antiretroviral medications. This regimen is known as "highly active antiretroviral therapy," or "HAART." CDC, *Living with HIV/AIDS*, *supra*; Evan Wood et al., *Expanding Access to HIV Antiretroviral Therapy Among Marginalized Populations in the Developed World*, 17 AIDS 2419, 2419 (2003). Each HAART regimen must be tailored to each individual patient. CDC, *Living with HIV/AIDS*, *supra*. If the HAART regimen is followed closely, the progression of HIV into AIDS usually can be delayed for many years—even decades.

Without health insurance, HAART is prohibitively expensive for most HIV/AIDS patients. The cost of HAART medication alone amounts to as much as $16,000 per year. Center for Health Law and Policy Innovation of Harvard Law School, *Massachusetts HIV/AIDS Resource Allocation Project* 15 (Working

Paper, Dec. 13, 2011). That is simply unaffordable for most: a 1998 study revealed that 46% of persons receiving treatment for HIV/AIDS had annual household incomes of less than $10,000, and 72% had incomes of less than $25,000. Samuel A. Bozzette et al., *The Care of HIV-Infected Adults in the United States*, 339 New Eng. J. Med. 1897, 1900 (1998). Moreover, 68% lacked private health insurance. *Ibid.*

Thus, uninsured adults with HIV who otherwise meet the income eligibility requirements for Medicaid are trapped in a catch-22. Although there are highly effective treatments that can prevent HIV's progression to AIDS—as well as stave off a host of HIV-related opportunistic infections, keeping disability at bay—most uninsured low-income adults lack access to these treatments because they are ineligible for Medicaid. It is only once the disease has progressed to AIDS or has made the individual disabled that they become eligible for Medicaid and gain access to HAART. Indeed, despite the ability of HAART to prevent AIDS, the vast majority of people receiving treatment have already progressed to AIDS. *Id.* at 1903 (60% of patients receiving treatment for HIV/AIDS already have AIDS, even though only about one-third of persons with HIV has AIDS). Our Nation's healthcare system is failing to adequately provide care to those with HIV at a stage of the illness in which the treatments can have the most significant impact.

The Affordable Care Act eliminates that catch-22 for many. Beginning in 2014, the Affordable Care

Act will make Medicaid available for all persons under the age of 65 whose income does not exceed 133% of the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). The Congressional Budget Office estimates that, by 2016, this Medicaid expansion alone will cover 16 million of the 50 million uninsured Americans. *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010: Hearing Before the Subcomm. On Health of the H. Comm. on Energy & Commerce*, 112th Cong. 18 tbl.3 (2011) (statement of Douglas Elmendorf). By effectively ending the disability requirement, the Affordable Care Act will make many more low-income persons living with HIV/AIDS eligible for Medicaid. That will dramatically increase access to HAART.

B. The Affordable Care Act's Medicaid Expansion Will Improve Quality Of Life For Persons With HIV

The most obvious benefit from making Medicaid available to low-income individuals with HIV/AIDS is that it will improve their quality of life.

HIV causes a chronic viral infection that nearly universally progresses to a devastating and debilitating disease and, ultimately, to premature death. Centers for Disease Control and Prevention, *Vital Signs: HIV Prevention Through Care and Treatment—United States*, 60 Morbidity and Mortality Weekly Report 1618, 1618 (2011) [hereinafter CDC, *Vital Signs*]. Without treatment, most individuals with HIV develop AIDS within 10 years of infection. *Ibid.*

The HAART regimen changes that dramatically. HAART is extremely effective at suppressing the amount of HIV in the bloodstream, often reducing it to undetectable levels. Over 75% of persons with HIV who follow the HAART regimen have suppressed viral load levels. *Id.* at 1619. Many people now can remain perpetually asymptomatic, not only preventing the disease's progression, but also staving off a number of HIV-related opportunistic infections. Apart from having to follow closely the HAART regimen and the possibility of side effects from the medication, HAART drastically improves quality of life. For those who have access to HAART, HIV is now essentially a chronic but manageable illness. *Wood* et al., *supra*, at 2419.

Since HAART was introduced in the 1990s, the number of deaths from AIDS has plummeted. Until 1994, the number of deaths steadily increased. Then from just 1995 to 1999, AIDS deaths dropped by 70% among men and 51% among women. Steep declines were seen in all demographic and risk groups. John M. Karon et al., *HIV in the United States at the Turn of the Century: An Epidemic in Transition*, 91 Am. J. of Pub. Health 1060, 1061-1064 (2001). Epidemiologists have concluded that the dramatic decrease in AIDS deaths was attributable primarily to HAART slowing the progression of the disease among people receiving treatment. *Id.* at 1065.

Despite the effectiveness of HAART, HIV/AIDS mortality persists in the United States. Although some HIV/AIDS deaths may be attributable to suboptimal adherence to the HAART regimen, the majority of deaths are due to limited access to HAART among disadvantaged or marginalized populations. Wood et al., *supra*, at 2420. These populations include many of the same groups that traditionally have had problems gaining access to quality health care, including individuals of lower socio-economic status, ethnic minorities, and users of intravenous drugs. *Ibid.* The Centers for Disease Control and Prevention (CDC) estimates that out of the 1.2 million people living with HIV in the United States, just 427,000 (36%) are on the HAART regimen, and only 328,000 (28%) have suppressed viral load. CDC, *Vital Signs*, *supra*, at 1621.

By making HAART available to many more low-income individuals living with HIV, the Affordable Care Act's Medicaid expansion is likely to save hundreds of thousands of lives. In addition to reducing the death rate, the Medicaid expansion will profoundly improve quality of life for those living with HIV—increasing not only their lifespan but also the number of years they will remain asymptomatic.

Indeed, where Medicaid expansion has been tested, these expected results have been proven. In 2001, Massachusetts received a waiver from the federal government to expand Medicaid coverage for people living with HIV/AIDS. Center for Health Law, *supra*, at 3. Under the State's Medicaid expansion, all individuals under 65 years of age with an income up to 200% of the federal poverty level who tested positive for HIV became automatically eligible for Medicaid enrollment. *Ibid.* The program has been a marked success. "People with HIV in Massachusetts are living longer than people with HIV elsewhere." *Id.* at 7. The number of HIV deaths in the State remained steady at around 400 per year from 1999 to 2003, but then over the next five years—from 2004 to 2008—the number of HIV/AIDS deaths dropped each year to a low of 250. *Ibid.* While the rate of deaths from HIV/AIDS has been declining slowly nationwide—from 4.9% in 2002 to 3.7% today—the rate in Massachusetts has dropped nearly twice as fast—from 3.5% in 2002 to 2% today. *Id.* at 7-8.

C. The Medicaid Expansion Will Greatly Reduce HIV Transmission

While it is intuitive that providing treatment to individuals with HIV/AIDS will reduce mortality and morbidity and will improve quality of life, the Medicaid expansion will have another less obvious—but just as important—benefit: it will substantially reduce the transmission of HIV.

According to the CDC, "successful use of [HA]ART by enough infected individuals could substantially reduce the spread of HIV within a population." CDC, *Effect of Antiretroviral Therapy on Risk of Sexual Transmission of HIV Infection and Superinfection*, at 1 (2009), http://www.cdc.gov/hiv/topics/

treatment/resources/factsheets/pdf/art.pdf [hereinafter CDC, *Effect of Antiretroviral Therapy*]. That is because most individuals diagnosed with HIV who receive HAART are able to reduce the amount of the virus in the bloodstream to undetectable levels. Julio S. G. Montaner et al., *The Case for Expanding Access to Highly Active Antiretroviral Therapy to Curb the Growth of the HIV Epidemic*, 368 Lancet 531, 531 (2006). Individuals with undetectable levels of the virus are less infectious in general and less likely to transmit HIV through sexual contact. CDC, *Effect of Antiretroviral Therapy*, *supra* at 1. Indeed, the level of HIV virus in the bloodstream—referred to as "viral load"—is the single largest predictor of the risk of heterosexual transmission of HIV. Montaner et al., *supra*, at 531. By boosting viral load suppression among the population of people with HIV/AIDS, the number of individuals who are able to transmit the virus will fall dramatically.

Recent studies provide compelling evidence that making HAART available to all persons with HIV/AIDS cuts in half the transmission of the virus in the population as a whole. In a study from Taiwan, there was a 53% reduction in new HIV-positive tests after free access to HAART was made available. Montaner et al., *supra*, at 532. And in British Columbia, Canada, HIV transmissions fell by about 50% between 1995 and 1998 after the introduction of HAART. *Ibid.* The results are even more compelling when HAART is introduced immediately upon infection. In a model of a program designed to control heterosexual HIV transmission through HAART initiation immediately upon testing positive for HIV, incidence of new HIV transmissions was reduced to less than 1 per 1000 persons per year. CDC, *Effect of Antiretroviral Therapy*, *supra*, at 5.

And a recent study among serodiscordant couples—couples in which one partner has HIV and the other does not—showed that early initiation of HAART led to a 96% reduction in HIV transmission to the uninfected partner. HIV Prevention Trials Network, *Initiation of Antiretroviral Therapy (ART) Prevents the Sexual Transmission of HIV in Serodiscordant Couples* (July 2011), http://www.hptn.org/web%20documents/HPTN052/HPTN%20Factsheet_InitiationART4Prevention.pdf. Another study showed that among heterosexual serodiscordant couples, transmission was reduced by 80% when the HIV-positive partner received HAART. CDC, *Effect of Antiretroviral Therapy*, *supra*, at 4.

Despite the effectiveness of HAART at reducing viral load, only about one fourth of all persons diagnosed with HIV in the United States are virally suppressed, mainly because only about half of individuals diagnosed with HIV are receiving regular care. CDC, *Vital Signs*, *supra*, at 1622. Making HAART more widely available, therefore, has tremendous potential to boost the number of persons living with HIV who are virally suppressed, and thereby substantially reduce rates of HIV transmission.

The results from Massachusetts's 2001 expansion of Medicaid are instructive. As a result of increased access to, and improved quality of, health care in Massachusetts, HIV/AIDS patients in that State have much higher rates of viral load suppression than the rest of the Nation. Center for Health Law, *supra*, at 10. By 2006, 65% of HIV/AIDS patients in Massachusetts had achieved total viral suppression, and 84% had viral loads under 400 (a key marker in HIV progression). *Ibid.* By expanding access to treatment nationwide, the Affordable Care Act is likely to achieve similar success at boosting viral load suppression and thereby substantially slowing the transmission of HIV.

In addition to reducing transmission through improved viral load suppression, the Medicaid expansion also is likely to stem HIV transmission through improved health care and health education among the non-infected population. "[S]ocioeconomic issues associated with poverty, including limited access to high-quality health care, housing, and HIV prevention education, directly and indirectly increase the risk for HIV infection and affect the health of people living with and at risk for HIV infection." CDC, *HIV Among African Americans* (Nov. 2011), http://www.cdc.gov/hiv/topics/aa/PDF/aa.pdf. Many of the population groups that are most at risk for new HIV infections are also the same groups that have limited access to health care. By making basic preventative health care widely available to many more low-income adults, the Medicaid expansion will educate non-infected persons about how to prevent transmission.

Moreover, making regular HIV screening more widely available will substantially reduce transmission. It is estimated that 21% of all persons living with HIV in the United States are unaware that they are infected. Elisa F. Long et al., *The Cost-Effectiveness and Population Outcomes of Expanded HIV Screening and Antiretroviral Treatment in the United States*, 153 Annals of Intern. Med. 778, 778 (2010). The majority of cases of sexual transmission of HIV occur from those who are unaware of their HIV-positive status. Gary Marks et al., *Estimating Sexual Transmission of HIV from Persons Aware and Unaware That They Are Infected with the Virus in the USA*, 20 AIDS 1447, 1449 (2006). Indeed the transmission rate among the unaware is 3.5 times as high as among those who are aware. *Ibid.* The Medicaid expansion will provide access to HIV screening that will inform more individuals about their HIV status and will empower newly diagnosed individuals to receive treatment and take other precautions to stop transmission earlier. These are all critical steps toward stopping the HIV/AIDS epidemic, and the Affordable Care Act will make them a reality.

D. Expanding HIV/AIDS Treatment Through Medicaid Is Cost-Effective

To be sure, providing HAART to more uninsured low-income individuals with HIV will be expensive.

But doing so is extremely cost-effective and in many ways will save money for participating States.

Because the HAART regimen is, for most people, extremely effective at slowing or stopping the progression of HIV, making HAART more widely available will decrease HIV/AIDS-related healthcare expenditures on acute and hospice care. Numerous studies have proven that the HAART regimen is cost-effective on this basis alone—without even considering other, more indirect benefits. Montaner et al., *supra*, at 532; Kenneth A. Freedberg, *The Cost Effectiveness of Combination Antiretroviral Therapy for HIV Disease*, 344 New Eng. J. Med. 824, 830 (2001).

Moreover, because the HAART regimen reduces the number of new HIV cases, the short-term investment in making HAART more widely available will pay off in the long run by reducing the number of persons diagnosed with HIV and in need of HAART. The CDC estimates that if the HAART regimen is not made more widely available, there are likely to be 1.2 million new HIV infections in the United States over the next 20 years. CDC, *Vital Signs*, *supra* at 1622. Based on estimated treatment costs of $367,000 per person over each individual's lifetime, caring for these new infections could cost as much as $450 billion. *Ibid.* But it is estimated that HAART will reduce later HIV/AIDS treatment spending by tens of billions of dollars each year—based on studies that have shown that the universal availability of HAART reduces HIV-transmission rates by about 50%. Montaner et al., *supra*, at 532-533. In other words, because HAART cuts transmission in half, it pays half its own way.

Expanding HIV treatment will also have economic benefits. Because the HAART regimen significantly extends the lifetime of persons with HIV/AIDS and staves off disability, persons with HIV who are receiving the HAART regimen have many more productive years than those not receiving therapy. Most persons who become infected with HIV do so in their younger and most productive years. Angela B. Hutchinson et al., *The Economic Burden of HIV in the United States in the Era of Highly Active Antiretroviral Therapy: Evidence of Continuing Racial and Ethnic Differences*, 43 J. Acquired Immune Deficiency Syndrome 451, 455 (2006). Thus, when AIDS cuts lives short, it does so with enormous costs to economic productivity. For example, the 40,000 new HIV infections in 2002 alone cost $30 billion in mortality-related productivity losses, measured by income forgone because of premature death. *Id.* at 453. That does not even include morbidity-related productivity losses, i.e., the income forgone because of disability. *Ibid.* Although the direct medical costs of expanding the HAART regimen to reach all persons living with HIV are estimated to be $1.2 billion, that investment actually would be cost-saving because it would reduce HIV/AIDS-related productivity losses by $3 billion. *Id.* at 454.

Those economic benefits will reduce States' expenditures on other public programs. Because the disability requirement in current Medicaid law requires most uninsured low-income people to become unable to work before they are eligible for treatment, an HIV diagnosis traps a low-income person into a cycle of poverty and dependence upon government assistance. Without the Medicaid expansion, States still would bear costs associated with HIV infection, but they would be spent on other public welfare programs.

The Medicaid expansion will also relieve some of the direct costs, currently borne in part by the States, associated with treating HIV/AIDS through the Ryan White HIV/AIDS Program. With contributions from both the federal government and the States, the Ryan White Program is a payer of last resort and funds AIDS Drug Assistance Programs (ADAPs) in each State. ADAPs provide HIV-related prescription drugs to low-income persons who have limited or no insurance coverage for prescription drugs. ADAPs are not entitlement programs; the number of enrollees is dependent upon the amount of funding available. Henry J. Kaiser Family Foundation, *HIV/AIDS Policy Fact Sheet: AIDS Drug Assistance Programs (ADAPs)* (Apr. 2008), http://www.kff.org/hivaids/upload/1584_09.pdf; Health Resources & Services Administration, U.S. Dep't of Health & Human Servs., *Part B—AIDS Drug Assistance Program*, http://hab.hrsa.gov/abouthab/partbdrug.html. With the recent economic crisis, demand for ADAP services has ballooned, while funding has fallen short, which has spurred some States to reduce program eligibility and institute waiting lists. The Medicaid expansion will allow

States to provide treatment to income-eligible individuals through Medicaid rather than ADAPs. That will save States money because, unlike ADAP funding, 90% to 100% of the Medicaid expansion is paid for by the federal government.

The expansion will also allow States to make better use of their Ryan White HIV/AIDS Program funding. For example, since Massachusetts expanded its Medicaid eligibility, its Ryan White HIV/AIDS Program funds are now focused on early intervention, expanding access to care, and providing support services, rather than paying for acute medical care. Indeed, Massachusetts has been able to expand its ADAP coverage to 481% of the federal poverty level (treating 1,500 more people), while decreasing the amount it spends on medications and keeping overall costs and funding flat. And unlike most States, Massachusetts's ADAP has no waiting list. Center for Health Law, *supra*, at 14-15.

In sum, not only is it inhumane to wait until individuals become disabled—as all untreated individuals with HIV eventually will—before providing essential care, it also makes no sense from either a public health or economic perspective.

CONCLUSION

The judgment of the Eleventh Circuit upholding the Medicaid expansion should be affirmed.

Respectfully submitted,

DEANNE E. MAYNARD
MARC A. HEARRON*
MORRISON & FOERSTER LLP
2000 Pennsylvania Ave., N.W.
Washington, D.C. 20006
mhearron@mofo.com
202.778.1663

**Counsel of Record*

Counsel for Amici Curiae

FEBRUARY 17, 2012

AMICUS
CURIAE
BRIEF

Nos. 11-393 and 11-400

In the Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, et al.,
Petitioners,
v.
KATHLEEN SEBELIUS, Secretary of Health and
Human Services, et al.,
Respondents.

STATE OF FLORIDA, et al.,
Petitioners,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICUS CURIAE* NATIONAL RESTAURANT ASSOCIATION IN SUPPORT OF PETITIONERS (SEVERABILITY)

LEON R. SEQUEIRA
Counsel of Record
DAVID M. WEINER
JENNIFER A. KRAFT
SEYFARTH SHAW LLP
975 F Street, NW
Washington, D.C. 20004
(202) 463-2400
lsequeira@seyfarth.com

Counsel for Amicus Curiae
National Restaurant Association

January 6, 2012

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

QUESTION PRESENTED

Whether the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub L. No. 111-152, 124 Stat. 109 (2010) (collectively the "Act"), must be invalidated in its entirety because it is not severable from the Act's individual mandate, 26 U.S.C. § 5000A, that exceeds Congress's limited and enumerated powers under the Constitution.

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INTERESTS OF *AMICUS CURIAE*[1]

This brief is submitted on behalf of the National Restaurant Association (the "Association") in support of petitioner. The Association is the leading business association for the restaurant and food service industry. The industry comprises 960,000 restaurant and food service outlets employing 12.8 million people who serve 130 million guests daily.[2] The restaurant industry is the nation's second-largest private-sector employer; more than nine percent of the U.S. workforce is employed in this industry.

The restaurant and food service industry is unique for several reasons. First and foremost, small businesses dominate the industry – with more than seven out of ten eating and drinking establishments being single-unit operators. This industry also employs a high proportion of part-time, seasonal, and temporary workers, with fluctuating and unpredictable work hours, as well as unpredictable lengths of service. The workforce is typically young, with nearly half of its employees being under the age of 25. The restaurant industry also has a high workforce turnover rate relative to other industries with a 75 percent average turnover rate in 2008 compared to a 49 percent average turnover rate for the overall private sector. In addition, the business model of the restaurant industry produces relatively low profit margins of only four to six percent before taxes, with labor costs being one of the most significant line items for a restaurant.

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[1] Pursuant to Supreme Court Rule 37.6, *amicus curiae* certifies that no counsel for any party authored this brief in whole or in part, and that no person other than amicus, its members, or its counsel made any monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Supreme Court Rule 37.3, amicus states that all counsel of record for all parties have filed with the Clerk's office letters of blanket consent to the filing of amicus briefs.

[2] *2011 Restaurant Industry Forecast*, National Restaurant Association.

This brief focuses on only one of the issues before the Court, the severability of the individual mandate from the other provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub L. No. 111-152, 124 Stat. 109 (2010) (collectively, the "Act").[3] In the event this Court finds that Congress exceeded its Constitutional authority in enacting the individual mandate, the Eleventh Circuit's decision regarding severability must be reversed, and the entire Act must be invalidated.

The Eleventh Circuit's decision incorrectly applies this Court's severability jurisprudence and fails to recognize the congressional objectives in passing the Act with numerous interrelated provisions. Moreover, if the Eleventh Circuit's decision on severability prevails, the Act will produce a U.S. health care system that no longer provides any risk-pooling mechanism and that is certain to accelerate dire financial impacts on those who provide health insurance, and on the restaurant industry in particular. These results contravene the congressionally-declared purposes of the Act.

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[3] The Association does not take a position as to whether the individual mandate is constitutional.

SUMMARY OF THE ARGUMENT

In the event the individual mandate in the Act is found unconstitutional, it cannot be severed from the whole and the entire Act is invalid. The Act was designed and intended by Congress as an integrated remedy to the shortcomings of the U.S. health care coverage system. As such, congressional intent will not be served by severing the individual mandate and leaving in place the remnants of the Act that are not being directly challenged here. If the other provisions of the Act remain in effect without the individual mandate, the Act will actually exacerbate many of the very problems Congress sought to ameliorate, and the cost of health care coverage will significantly increase. The restaurant industry will be hit especially hard, by virtue of the demographics of its workforce and the characteristics of its employers.

Particular features of the Act, such as the ban on preexisting condition exclusions, the ban on lifetime and annual limits, and the requirement for coverage of adult children will, in the absence of the individual mandate, result in increased health insurance costs for employers and individuals seeking insurance coverage. In response, many restaurant industry employers will no longer be able to afford to provide *any* health care coverage to their employees, forcing those employees to seek coverage from government-subsidized sources, which will increase the burden on U.S. and state taxpayers, and undermine the private employer-based health insurance system.

ARGUMENT

I. THE INDIVIDUAL MANDATE IS NOT SEVERABLE FROM THE ACT

Introduction

The Act is one of the most far-reaching and complicated statutory regimes enacted by Congress in recent memory. The nearly 2,700 pages of statutory language and the thousands of attendant regulations impose (or will impose) countless intertwined obligations on individuals, employers and state governments. The Act's mandate that individuals must purchase health insurance is the central element of this regime to which virtually all of the other reforms in the Act directly or indirectly relate. Without the individual mandate in place to facilitate and fund the Act's other insurance and health care reform provisions, those remaining provisions cannot fulfill Congress's stated goals in passing the Act.

The district court found the individual mandate to be contrary to Congress's power under the Constitution and, after considering this Court's precedents on the severability doctrine, correctly determined that the individual mandate could not be severed from the rest of the Act.

The Eleventh Circuit, in reversing the district court's decision on severability, incorrectly applied this Court's severability jurisprudence and failed to properly recognize the congressional intent in crafting the Act's provisions to function as an interrelated whole.

A. The Presumption of Severability Does Not Apply to the Act

This Court recently reaffirmed the doctrine of severability by noting that "[g]enerally speaking, when confronting a constitutional flaw in a statute, we try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. —, —, 130 S.Ct. 3138, 3161 (2010) (citation and internal quotations omitted).

This presumption of severability of the offending provision has also been characterized as the "normal rule that partial, rather than facial, invalidation is the required course." *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 504 (1985).

The Court's use of the terms "generally speaking" in *Free Enterprise Fund*, and "normal rule" in *Brockett* necessarily implies that there are instances when severability is not the proper remedy for a constitutionally flawed statute. The unprecedented reach of the Act and the dramatic effects its interrelated provisions have (or will have) on one-sixth of the U.S. economy is a clear indication that this is not a typical case involving a question of whether to sever a discrete statutory provision. Indeed, if this case does not present the circumstances mandating departure from the "normal rule" of severability, it would be difficult to imagine the scenario warranting such a departure.

Determining whether an unconstitutional provision can be severed from the remainder of the statute hinges on whether the provisions that would remain can function "in a *manner* consistent with the intent of Congress" in passing the Act. ***Alaska Airlines, Inc.*** *v.* ***Brock***, 480 U.S. 678, 685 (1987) (emphasis in original).

Although many remaining provisions of the Act may technically function[4] in the absence of the individual mandate, it is clear that they would not function in accord with Congress's overall objectives and intent in passing the Act.

B. Congress Intended the Act's Provisions to Function as an Interrelated Whole

1. Congress Declared the Mandate Essential to Achieving the Purposes of the Act

The Act is a carefully crafted legislative compromise consisting of numerous provisions each of which, by virtue of its inclusion in the Act, was necessary to the design and ultimate passage of the interrelated reforms devised by Congress to address the ills in the U.S. health care system.

The lynchpin of these myriad reform provisions is the individual mandate, which the congressional findings accompanying the Act repeatedly refer to as the "essential" element upon which achievement of the Act's objectives depends. *See, e.g.,* 42 U.S.C. § 18091(a)(2)(I) ("the requirement [to purchase insurance] is essential to creating effective health insurance markets").

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[4] Indeed some provisions of the Act have already gone into effect.

Congress described its objectives in the Act's findings, which include adding millions of new consumers to the health insurance market, 42 U.S.C. § 18091(a)(2)(C); achieving near-universal coverage and strengthening the private employer-based health insurance system, 42 U.S.C. § 18091(a)(2)(D); lowering health insurance premiums, 42 U.S.C. § 18091(a)(2)(F); improving financial security for families, 42 U.S.C. § 18091(a)(2)(G); and broadening the health insurance risk pool to include healthy individuals, 42 U.S.C. § 18091(a)(2)(I). Each of the congressional findings notes that these objectives were to be accomplished either solely by the individual mandate or by the individual mandate operating in conjunction with other provisions of the Act.

Indeed, the Act's most wide-ranging objective of adding millions of new consumers to the health insurance market through the individual mandate would likely lead to the fulfillment of the other objectives given Congress's realization that healthy individuals make up a significant portion of the currently uninsured and their insurance premiums would offset additional costs associated with the Act's other reforms that expand coverage.

2. Severing the Mandate Conflicts with Congress's Intent that the Act Function as an Integrated Whole

"[T]he touchstone for any decision" about whether to sever an offending provision from the rest of the Act, "is legislative intent." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006). In crafting the Act, Congress recognized that without an individual mandate, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(a)(2)(I). Individuals who forego the advance purchase of insurance and who later need medical care are those who are often excluded from the insurance market as a result of pre-existing conditions and/or are those who often have their medical expenses shifted to others in the health care system.

Congress addressed these uninsured and cost-shifting problems in the Act by requiring individuals, including those who are healthy, to purchase and maintain health insurance. The individual mandate also serves to achieve near-universal coverage that broadens the risk pool and provides financing to cover costs associated with other reforms in the Act, including the guaranteed issue provision, the prohibition on insurance eligibility based on health status, and the community rating provision. *See* 42 U.S.C. §§ 300gg-1(a), 300gg-4, 300gg-(a)(1).

The objectives underlying the Act plainly reveal Congress's intent that the individual mandate is designed to work in conjunction with other provisions in the Act to solve the identified shortcomings in the health care system. Thus, the absence of the individual mandate as part of that reform regime "pose[s] a critical problem" for the Act to function as intended. *United States v. Booker*, 543 U.S. 220, 260 (2005).

Indeed, severing the individual mandate would leave in place a set of reforms untethered from their anchor that, rather than fulfill Congress's objectives in passing the Act, would actually exacerbate the problems Congress set out to ameliorate. *See* discussion *infra* Part II.

Such a result surely satisfies the requirement that for the entire Act to be invalidated, it be "evident that Congress, faced with the limitations imposed by the Constitution, would have preferred no [Act] at all" to the Act that remains. *Free Enter. Fund*, 130 S.Ct. at 3161 (internal quotations and citations omitted).

C. Attempting to Assess Whether Additional Provisions Should be Severed Would Require the Court to Infringe on the Role of the Legislature

Although it may be theoretically possible to parse every line in the 2,700 page statute in an attempt to determine congressional intent with respect to each provision, and whether and to what extent each is related to the individual mandate, and should be severed from the Act, such an exercise would overstep the purview of the Court and infringe on the role of the legislature. *See Ayotte*, 546 U.S. at 329-30 ("making distinctions . . . where line-drawing is inherently complex, may call for a 'far more serious invasion of the legislative domain' than we ought to undertake").

Therefore, rather than attempting to determine congressional intent with regard to every provision and its relation to the individual mandate, the entire interrelated Act should be invalidated, so that Congress may exercise its proper role and determine whether any of the remaining provisions should be enacted absent the individual mandate.

II. SEVERING THE INDIVIDUAL MANDATE FROM THE ACT WILL LEAD TO RESULTS CONGRESS DID NOT INTEND

Introduction

The Act is Congress's attempt at a comprehensive approach to implementing reform in the health insurance market. The provisions are complex and intertwined, because Congress determined that only an integrated approach could address the various problems affecting the health care system.

Congress sought to address what it identified as two major shortcomings in the current system: (1) that many Americans who want or need coverage cannot obtain it, or can only obtain part of the coverage they need; and (2) that the risk pooling system is flawed because many healthy people do not elect to be covered. The Act addressed these problems by extending coverage generally and broadening the scope of coverage to those already covered; and by mandating certain employers make coverage available to individuals, and by mandating that each individual maintain coverage. Much of the first part of these reforms has already become effective or will become effective before 2014, with universal availability of insurance and the individual mandate becoming effective in 2014.

Of the various provisions of the Act, the individual mandate is the most critical because it is the primary mechanism to achieve near-universal health insurance coverage, including among the relatively young and healthy. Without the mandate, the Act creates a perverse system offering widespread availability and a broad scope of coverage without any true functioning "insurance" mechanism. Instead of obtaining insurance in *advance* as a hedge against potential future health care costs, the insurance could be accessed "just in time" by individuals right before medical care is needed.

A lack of near-universal coverage and corresponding influx of insurance premiums from relatively healthy individuals, who would otherwise largely opt-out of medical insurance absent the mandate, will deprive the system of needed revenue to finance the expanded coverage mandated by the Act. This will undoubtedly lead to a spiraling increase in medical costs, particularly as more individuals with costly pre-existing conditions are provided insurance at rates unrelated to their actual health risk.

The rising costs of health care will make insurance premiums increasingly expensive, which will, in turn, force more individuals from the private insurance market and into government-sponsored plans, thereby shrinking the risk pool and causing insurance costs to rise even more.

In other words, the Act without an individual mandate creates a system that is more expensive because there is no true risk pool where the health care costs of the participants can be financed by the insurance premiums of both the healthy and the sick. Instead, it produces a system that mandates only the sick and injured be covered and, therefore, only those individuals will be paying insurance premiums in advance to finance health care. Such a regime is unsustainable.

Another indication of the individual mandate's central role in the Act is the inclusion of staggered effective dates for many of the health insurance provisions, with the substantive health insurance reforms going into full effect in 2014, when the individual mandate becomes effective. For example, the Act requires preexisting condition exclusions to be eliminated for dependent children for plan years beginning on or after September 23, 2010, but requires preexisting condition exclusions to be eliminated for *all* participants by 2014, when the individual mandate is scheduled to be effective. *See* 42 U.S.C. § 300gg-3.[5] Similarly, the Act prohibits health plans from including lifetime limits on essential health benefits for plan years beginning on or after September 23, 2010, and permits only reasonable annual limits on essential health benefits until 2014. *See* 42 U.S.C. § 300gg-11(a)(1)(A), (b). Beginning in 2014, however, when the individual mandate is scheduled to go into effect, the Act prohibits *all* annual limits on essential health benefits. *Id.*[6]

Congress's decision to tie the effective dates of various provisions to the effective date of the individual mandate reflects the central importance of the mandate to the effective implementation of the Act's other reforms. Without the individual mandate, the rest of the provisions in the Act produce unbalanced changes that are unable to achieve Congress's objectives for reform of the health care and insurance system.

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[5] For dates effective as to children and then adults, *see* Pub. L. No. 111-148, Title I, § 1255 (formerly § 1253), 124 Stat. 162 (2010) (renumbered § 1255 and amended, Pub. L. No. 111-148, Title X, § 10103(e), (f)(1), 124 Stat. 895 (2010), and codified in note to 42 U.S.C. § 300gg-3).

[6] In addition, the Act permits grandfathered plans to exclude adult dependent children who are eligible to enroll in their own employer-sponsored plan from coverage, but only until 2014 when the individual mandate goes into effect. *See* 42 U.S.C. § 18011.

A. The Remaining Provisions of the Act Would Create Dire Consequences for the Health Insurance Market

If the individual mandate is found unconstitutional and the rest of the Act continues in effect, the health insurance market would suffer a significant adverse financial impact contrary to Congress's intent in passing the Act.[7]

The Act's prohibition on preexisting condition exclusions and lifetime limits (which were common practices in the health insurance market before passage of the Act) while expanding coverage for adult children, drastically increases the potential liabilities for those who provide health insurance. With the individual mandate, this financial impact would be somewhat offset by the increased number of healthy individuals obtaining coverage and thus contributing premiums without consuming health care services.

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[7] *See* Brief of America's Health Insurance Plans as *Amicus Curiae* in Partial Support of Certiorari Review in this case, pp. 6-8, 15-22 ("Empirical evidence thus strongly indicates that a system of market reforms unaccompanied by an individual mandate would create widespread and potentially economically disabling instability in the insurance market and, over time, would substantially reduce access to affordable coverage."); *see also* 42 U.S.C. § 18091(a)(2)(I) ("By significantly increasing health insurance coverage, the requirement [to purchase insurance]. . . will broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums").

Without this individual mandate, however, this drastic increase in liabilities for those who provide health insurance is not offset at all. Indeed, healthy individuals may not purchase any type of health care insurance until they are actually sick, and at that point the Act requires group health plans to provide them coverage. Thus, implementing the rest of the Act's provisions related to health insurance without the individual mandate would have a significant negative economic impact on insurers and employers providing health insurance coverage.

The preventive service provisions of the Act also underscore how the individual mandate is inextricably linked to the overall solution crafted by Congress. When individuals receive preventive services, the cost of health care in the long run is reduced.[8] The Act requires group health plans to provide 100 percent coverage for preventive services. *See* 42

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[8] *See* Preamble to *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act,* 75 Fed. Reg. 41726, 41735 ("Increasing the provision of preventive services is expected to reduce the incidence or severity of illness, and, as a result, reduce expenditures on treatment of illness. ....Researchers at the Centers for Disease Control and Prevention (CDC) ... found that every dollar spent on immunizations in 2001 was estimated to save $5.30 on direct health care costs and $16.50 on total societal costs of the diseases as they are prevented or reduced (direct health care associated with the diseases averted were $12.1 billion and total societal costs averted were $33.9 billion)).

U.S.C.§ 300gg-13(a).[9] Although this expanded coverage would represent additional costs to the health care system, the individual mandate could be expected to help offset these costs. This would occur because individuals with coverage (as a result of the mandate) would be more likely to avail themselves of preventive care, enabling doctors to identify and treat ailments earlier and at a much lower cost than if such conditions were discovered and treated in later stages as a serious health condition.

Without the individual mandate, however, individuals can drop in and out of coverage only when they think they need medical care and, without continuous coverage, will be less likely to seek out preventive services. As a result, the Act's expanded coverage for preventive services will increase costs in the health care system without the counterbalancing reduction in costs attained through early treatment of ailments among those who fail to maintain coverage and access to preventive care.

Congress recognized the critical nature of the individual mandate and the dangers posed by this adverse selection. In fact, Congress explained in the Act's findings its intent for the individual mandate to "minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." 42 U.S.C. § 18091(a)(2)(I).

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[9] The Act provides that plans with minimal changes, considered "grandfathered" are not required to meet this requirement, but the Department of the Treasury, Department of Labor and Department of Health and Human Services estimated that by 2013 up to 80 percent of small employer plans would lose grandfathered status. *See* Preamble to 26 C.F.R. 54.9815-1215T, *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as Grandfathered Health Plan and the Patient Protection and Affordable Care Act,* 75 Fed. Reg. 34553 (June 17, 2010). Thus, this requirement would apply to most restaurant industry group health plans.

B. The Restaurant Industry Will Be Particularly Impacted by the Remaining Burdensome Provisions of the Act

The demographics of the restaurant workforce and the characteristics of most restaurant employers means the industry would be subject to a particularly negative impact if the individual mandate is severed from the rest of the Act.

1. Younger Workers are More Likely to Forego Coverage

With the individual mandate in place, more people, including relatively healthy people, will be in the insurance pool and contributing to the cost of coverage. Without the individual mandate, however, individuals could take a "wait and see" approach and elect coverage under an employer's plan only after being diagnosed with a serious illness or experiencing an accident that requires rehabilitative treatment.

This adverse selection concern would be most prevalent among younger, healthier individuals, with more limited income. Absent an individual mandate, workers who fit this profile are likely to decline health care coverage until they have an immediate need for care.

This result would have a disproportionate impact on restaurant employers because so much of their workforce is made up of precisely this demographic. Nearly half of the workers in the restaurant industry are under age 25 and the vast majority are employed on an hourly basis. An internal 2007 industry survey revealed that nearly three-fourths of the industry's hourly workforce does not elect to participate in employer-provided health plan coverage.

In addition, restaurant employees often work fewer hours and earn less compensation, on average, than the overall United States workforce. Thus, the cost of health care coverage would take up even more of these employees' disposable income and, without the individual mandate, they would have little incentive to enroll in their employers' health plans until they actually needed coverage for a particular condition. In fact, in the absence of the mandate, these individuals will have even *less* incentive to enroll than they do now because the employers' future health plans will be more expensive as the remaining reforms in the Act drive up costs (with a higher proportion of unhealthy people in the risk pool worsening that trend), and the downside to waiting to elect coverage (i.e., that preexisting conditions would not be covered) is eliminated.

If an individual needed health care at a certain point, the individual could either wait for the employer's annual enrollment period to become covered by the employer's plan, or, in light of the high turnover rates in the restaurant industry, the individual could instead obtain employment with a new employer and become enrolled immediately without waiting for the annual enrollment period.

In either case, the result is that restaurant plans are more likely to experience low enrollment with the majority of the employees who elect coverage being those requiring expensive medical treatment. This scenario would lead to steep increases in the cost of coverage and many restaurant owners no longer being able to provide *any* coverage whatsoever to their workforce. This result would undermine the employer-provided health care system, contrary to Congress's intent in passing the Act. *See, e.g.*, 42 U.S.C. § 18091(a)(2)(D) ("the requirement [to purchase insurance] achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system").

2. Industry Employers Will Be Adversely Affected by the Cost of Partial Implementation of Health Care Reform

The restaurant industry is composed overwhelmingly of small employers. Congress's goal of helping small employers provide health coverage would be impeded by the large increase in the cost of health care coverage, which would result if the rest of the Act stands without the individual mandate requirement. Congress's intent to help small employers provide health coverage is evidenced by numerous provisions of the Act.[10] If the Act is implemented without the individual mandate, however, it would affirmatively place small employers, and their employees, in a *worse* position than they were before passage of the Act. The Act's other reforms would increase the cost of coverage so much that many small employers will not be able to afford to offer their employees any coverage. Thus, the special provisions targeted to help small employers provide health care coverage to their employees would be largely useless.

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[10] For example, the Act provides a small business tax credit for qualifying employers' contributions toward their workers' health insurance premiums, 26 U.S.C. § 45R; authorizes grants to small employers to create wellness programs, 42 U.S.C. § 280l; and, creates a safe harbor from certain nondiscrimination testing rules for small employers through the use of a simple cafeteria plan for pre-tax contribution funding, 26 U.S.C. § 125(j). In addition, the

In addition, employers subject to the employer mandate would be even *more* likely to be subject to additional penalties if the Act is implemented without the individual mandate. The Act requires that an employer with the equivalent of at least 50 full-time employees must either offer its full-time employees and their dependents the opportunity to enroll in "affordable" minimum essential coverage or pay a penalty. *See* 26 U.S.C. §§ 36B, 4980H. While many restaurant employees are considered part-time, the Act requires that any employee working only 30-hours per week would be considered full-time, and an employer meeting the threshold of 50 employees would either need to offer these individuals affordable coverage or face a penalty.

As noted above, the other remaining requirements of the Act would greatly increase the cost of coverage, but the Act's "affordability" restriction on employers means they cannot charge an employee more than 9.5

Act requires the creation of State Exchanges as a means for small employers to have access to affordable health care coverage for their employees. *See* 42 U.S.C. § 18031.

percent of the employee's household income for coverage.

Restaurant employers, whose workforce tends to have lower household incomes, would need to keep the employee premium at an even lower relative dollar amount to meet this 9.5 percent threshold. Consequently, restaurant employers would inevitably have to absorb a disproportionately high share of the dramatic price increases caused by the Act or pay penalties for not offering coverage. In either case, the private employer-based health insurance system will be weakened, rather than strengthened as Congress intended. *See, e.g.*, 42 U.S.C. § 18091(a)(2)(D).

3. Without the Individual Mandate, the Offerings for Small Employers in the State Exchanges Would Be More Expensive

Congress included provisions in the Act for States to create health care Exchanges through which individuals and small employers would be able to purchase coverage beginning in 2014. *See* 42 U.S.C. § 18031.

As described above, the Act's expansion of insurance coverage to the previously uninsured generally increases the cost of health insurance. With the individual mandate, the insurance risk pool would dramatically expand, enabling insurers to distribute costs across the wider pool and offer lower-cost premiums. The Exchanges would, thus, help small employers, like many of those in the restaurant industry, access insurance coverage for their employees.

Without the individual mandate, however, fewer individuals will be included in the risk pool pricing for insurance available on the Exchanges. As a result, the Exchanges will not function as intended to provide small employers with additional insurance coverage options for their employees.

CONCLUSION

Should this Court find Congress exceeded its authority in enacting the individual mandate, the judgment of the Eleventh Circuit severing the mandate from the rest of the Act must be reversed and the entire Act must be invalidated.

Respectfully submitted,

LEON R. SEQUEIRA
Counsel of Record
DAVID M. WEINER
JENNIFER A. KRAFT
SEYFARTH SHAW LLP
975 F Street, NW
Washington, D.C. 20004
(202) 463-2400
lsequeira@seyfarth.com

Counsel for Amicus Curiae

AMICUS
CURIAE
BRIEF

No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, *et al.*,

Petitioners,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

On Writ of Certiorari to the United
States Court of Appeals for the Eleventh Circuit

Brief of the States of Oregon, Vermont, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Mexico, and New York, and the Governor of Washington as Amici Curiae in Support of Respondents

(Addressing Medicaid Expansion)

JOHN R. KROGER
Attorney General of Oregon
***ANNA M. JOYCE**
Solicitor General
KEITH DUBANEVICH
Chief of Staff
1162 Court Street
Salem, Oregon 97301-4096
Phone: (503) 378-4402
anna.joyce@doj.state.or.us
Counsel for *Amici Curiae*
State of Oregon

WILLIAM H. SORRELL
Attorney General of Vermont
BRIDGET C. ASAY
Assistant Attorney General
109 State Street
Montpelier, Vermont 05609
Phone: (802) 828-3173
basay@atg.state.vt.us
Counsel for *Amicus Curiae*
State of Vermont

***Counsel of Record**

[Additional Counsel Listed On Inside Cover]

QUESTION PRESENTED

Does Congress exceed its authority under the Spending Clause by expanding eligibility for Medicaid and by giving the Secretary of the Department of Health and Human Services discretion to withhold some or all Medicaid funds from States that fail to implement that expansion?

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INTEREST OF AMICI STATES

Amici, the States of Oregon, Vermont, California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Mexico, and New York, and the Governor of Washington, have no more important duty than protecting the health and safety of their citizens. To fulfill that duty, amici must ensure that their citizens have access to affordable health insurance. Amici also have a vital interest in ensuring that the federal government respects constitutional principles of federalism. Amici have long been committed to finding innovative ways to improve access to quality health care for their citizens and have a particular interest in reforms that do not encroach on State autonomy or restrict States' ability to shape healthcare policy. The Patient Protection and Affordable Care Act of 2010 ("ACA") is a comprehensive national solution to the nation's healthcare crisis that embraces principles of cooperative federalism and allows the States to substantially expand and improve health insurance coverage.

The ACA achieves increased coverage through a variety of mechanisms, including an expansion of the Medicaid program. The law will expand Medicaid eligibility to nearly all non-elderly adults who earn up to 133% of the federal poverty level ("FPL"). While some States have already expanded Medicaid eligibility to those levels, the vast majority have not. Nationally, the expansion is expected to decrease the number of uninsured persons by approximately 11.2 million, or 45% of uninsured adults below 133% of the

FPL.[1] In Oregon, for example, the ACA reforms will allow the State to reduce the number of uninsured to just 5% by 2019—a vast improvement over the 23.8 to 27.4% rate of uninsured predicted without the reforms.[2]

Those gains in coverage will come at little or no cost to the States. Although more people are expected to enroll in Medicaid under the ACA, the federal government will cover virtually all of the costs of newly eligible enrollees. As a result, Medicaid enrollment nationally is estimated to increase 27 percent by 2019, but average State spending will increase by only 1.4 percent.[3] Without healthcare reform, however, the States face the possibility of increasing enrollment without supplemental federal funding.

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[1] Kaiser Comm'n on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform* 10, tbl. 1 (May 2010), *available at*
http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf

[2] Bowen Garrett et al., *The Cost of Failure to Enact Health Reform: Implications for States* 51 (Oct. 1, 2009), *available at*:
http://www.urban.org/uploadedpdf/411965_failure_to_enact.pdf

[3] Kaiser Comm'n, *supra* note 1, at 10, tbl. 1.

The Medicaid expansion significantly changes *who* is eligible for Medicaid, but the ACA does not change the basic structure of the program or *how* the program is implemented. Medicaid has always been a cooperative partnership between the federal government and the States, and the ACA does not change that. The Act continues the tradition of State flexibility and experimentation that has been the hallmark of cooperative federalism, by allowing the States to apply for federal grants, seek waivers, operate demonstration projects, and otherwise exercise discretion in implementing Medicaid. The ACA thus strikes an appropriate, and constitutional, balance between national requirements that will expand access to affordable healthcare and State flexibility to design programs that achieve that goal.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress created the Medicaid program more than 45 years ago as a way to help States provide healthcare to their neediest citizens. Under the program, participating States create and administer their own individual Medicaid plans, while acting within broad federal standards. All 50 states, the District of Columbia, and the U.S. Territories now participate in the program.

The ACA amends the Medicaid program, most notably by expanding eligibility for coverage, beginning January 1, 2014, to all non-elderly, non-Medicare-eligible adults whose incomes do not exceed 133% of the FPL. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). At issue here is whether Congress coerced the States when it expanded Medicaid eligibility and gave the Secretary of the Department of Health and Human Services ("the Secretary") discretion to withhold Medicaid funding from States that fail to comply with the new eligibility requirements.

Amici—every bit as much as petitioners—are conscious of the threat posed to our liberty and our federalist system when Congress oversteps its authority. Amici thus understand the "gravity of the task of appropriately limiting the spending power." *South Dakota v. Dole*, 483 U.S. 203, 217 (1987) (O'Connor, J., dissenting). Amici remain vigilant in guarding against any Congressional attempt to strong-arm the States by abusing its spending authority. But Congress has not overstepped its authority or strong-armed the States in enacting the ACA's Medicaid expansion.

Requiring States to expand Medicaid eligibility to individuals whose income does not exceed 133% of the FPL is not coercive, nor is it an attack on the federalist system. In a cooperative federalist program, the federal government establishes the program's core requirements and gives the States the freedom to implement their own programs within those requirements. The Medicaid program has been popular and successful because it has adhered to that model. The ACA's Medicaid expansion does not change that fundamental arrangement, and it is entirely consistent with the history of the program. While expanding Medicaid's basic eligibility standards, the ACA does not disturb the States' autonomy and freedom to experiment that has always been a hallmark of the program.

Over the last four decades, Congress has repeatedly required States choosing to participate in Medicaid to extend coverage to new populations in response to evolving policy concerns. That is consistent with the principles of cooperative federalism: Because Medicaid's eligibility standards are a core element of the program, the government permissibly may withhold Medicaid funds from States that fail to comply. By doing so, Congress is not coercing the States; it is simply defining the basic nature of the program. The same is true of the ACA's Medicaid expansion.

Historically, Congress has not acted alone in expanding Medicaid. The States have taken advantage of their freedom to experiment by extending eligibility to additional categories of the poor, beyond the mandatory coverage groups. After individual States have successfully expanded coverage, Congress often follows their lead by making expanded coverage mandatory. The ACA's Medicaid expansion follows the same pattern. The States have taken a leading role in developing the very innovations that Congress adopted in the ACA, including the eligibility expansion. Far from being an attack on federalism, the Medicaid expansion reflects a cooperative federalist program that is functioning just as it should.

The ACA also does not alter the fact that participation in Medicaid is voluntary. Congress structured the ACA and the timeline for its implementation in a way that makes it possible for States choosing to withdraw from Medicaid to do so. Although withdrawing from the program may be difficult and politically unpopular, it remains an option.

Petitioners' facial challenge to the Medicaid expansion also fails because it rests on a false premise. Petitioners presume that Congress has required the States to implement the expansion or leave Medicaid. But that is not what Congress has done. To the contrary, Congress gave the Secretary *discretion* to determine an appropriate response—withholding some or all Medicaid funds—for States that do not implement the Medicaid expansion. Because the law expressly gives the Secretary that discretion, the law necessarily is capable of constitutional application and thus is not facially coercive.

ARGUMENT

I. Congress may not use its spending power to coerce the States into action, but it has broad authority to define the core standards of a cooperative federalist program.

Congress may use its spending power to persuade the States to pursue federal policy goals, but it may not go so far that its influence constitutes outright coercion. *Dole*, 483 U.S. at 211; *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937). That principle constrains Congress's power to attach conditions on federal funding, even for cooperative and voluntary programs like Medicaid. But at the same time, Congress has broad power to define the basic standards and policy objectives of such programs. Because of those competing principles, identifying the point at which federally imposed requirements become unconstitutionally coercive is necessarily a fact-specific inquiry, and, as explained below, one that must involve a careful examination of the program as a whole.

The constitutional limits on Congress's spending power are crucial for State autonomy and for our system of divided sovereignty. *See Bond v. United States*, 131 S. Ct. 2355, 2366 (2011). If the spending power were unconstrained, then Congress could exercise it in ways that would undermine State authority and override local policy preferences. *See Davis v. Monroe County Bd. of Ed.*, 526 U.S. 629, 654-55 (1999) (Kennedy, J., dissenting) ("[T]he Spending Clause power, if wielded without concern for the federal balance, has the potential to obliterate distinctions between national and local spheres of interest and power by permitting the Federal Government to set policy in the most sensitive areas of traditional state concern[.]"); *Dole*, 483 U.S. at 217 (O'Connor, J., dissenting) (arguing that spending power cannot be limited solely by "Congress'[s] notion of the general welfare"). For those reasons, the States are rightly "vigilant in policing the boundaries of federal power." *Davis*, 526 U.S. at 655 (Kennedy, J., dissenting).

Yet the States do not have an interest in advancing an unduly restricted vision of federal power. States often face obstacles to pursuing desired policies and favor federal action to remove those obstacles. For example, States may wish to make healthcare available to more people, but may fear that expanding their Medicaid program will inadvertently attract applicants from States that retain stricter standards, thereby overburdening the system.

Expansion of Medicaid at the national level provides a way to overcome that barrier to coverage. And Medicaid is just one example of many programs where the States and the federal government have "join[ed] in a cooperative endeavor to avert a common evil." *Steward*, 301 U.S. at 587. For amici, the crucial concern is that the limits on federal power must be sufficient to protect State authority while also preserving the benefits of cooperative federal-State programs.

For these reasons, the inquiry into whether Congress has overstepped its spending authority by changing the conditions for participating in a federal program is necessarily fact-specific, and must involve an examination of the program as a whole, including the purpose of the program, the types of conditions imposed, and the cost of noncompliance. *See Steward*, 301 U.S. at 590 ("[T]he location of the point at which pressure turns into compulsion, and ceases to be inducement, would be a question of degree,—at times, perhaps, of fact."); *Dole*, 483 U.S. at 211 (holding that the federal funding at stake—approximately five percent of the State's federal highway funds—was "relatively mild encouragement," and thus the State's coercion argument was "more rhetoric than fact").

Congress has the most leeway when it is designing core elements of a federal program that are intended to carry out the federal policy objective. That is because Congress has the prerogative to expend federal funds consistently with its own view of the "general [w]elfare of the United States." U.S. Const. art. I, § 8, cl. 1. On the other hand, if Congress conditions receipt of a large amount of money on compliance with an unrelated or attenuated requirement, or a relatively minor aspect of a program, the risk of coercion is significant and the Court's review should be searching. This Court's review should focus on the distinction between core elements of a federal program and tangential or minor requirements.

In analyzing a claim of coercion, this Court should also consider whether Congress has provided a meaningful role for the States to play. A Spending Clause program that required States to implement, without exception, a program designed by the federal government would raise questions about the constitutional balance between the State and federal governments. In contrast, a truly cooperative program that affords the States flexibility in its implementation is unlikely to be coercive.

II. The ACA's Medicaid expansion is not coercive.

A. The ACA continues Medicaid's longstanding model of cooperative federalism.

1. Medicaid remains a cooperative program that affords the States substantial flexibility and autonomy.

Since its inception, Medicaid has been a voluntary and cooperative program, under which "the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons." *Harris v. McRae*, 448 U.S. 297, 308 (1980). States that choose to participate must adhere to core requirements established by Congress but are given substantial flexibility to tailor their programs as needed. The program "allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory programs, structured to meet their own particular needs." *Hodel v. Virginia Surface Mining & Recl. Assn., Inc.*, 452 U.S. 264, 289 (1981).

The ACA does nothing to change that cooperative structure and, in fact, further promotes Medicaid's longstanding cooperative approach. As before, the States remain free to determine, within broad federal guidelines, the benefits that will be offered and how the program will operate. 42 U.S.C. § 1396a. And as before, the States can take advantage of Medicaid waiver programs to expand access to health insurance or test different approaches to providing care. *See* 42 U.S.C. § 1396n (providing various waiver programs); 42 U.S.C. § 1315 (permitting waiver of standard Medicaid requirements for "any experimental, pilot, or demonstration project" that, in the Secretary's discretion, "is likely to assist in promoting the objectives of" Medicaid).

And the ACA creates new ways for the States to innovate within Medicaid. For example, Oregon officials are already in the process of planning a health home program under section 2703 of the ACA, *see* 42 U.S.C. § 1396w-4 (codifying section 2703 of the ACA and allowing waiver for health home programs), to allow for better coordination and management of the health and long-term services provided to Medicaid recipients with multiple or severe chronic conditions. The Act also creates incentives for states to "rebalance" their Medicaid long-term care systems away from institutional care to home and community-based settings, where appropriate. *See* 42 U.S.C. § 1396n(k). This provision was based on Washington's experience with such rebalancing. In addition, the ACA creates the Center for Medicare and Medicaid Innovation ("CMI"), which will "test innovative payment and service delivery models." 42 U.S.C. § 1315a. One way for CMI to do so is by "[a]llowing States to test and evaluate" different payment systems. 42 U.S.C. § 1315a(b)(2)(B)(x) & (xi).

In attempting to dispute the cooperative nature of the ACA, petitioners exaggerate the burdens that the Medicaid amendments impose. For example, the provisions setting minimum standards for Medicaid coverage do not place a "new and onerous requirement" on the States, Pet. Br. 8. Instead, the States retain the ability to determine the particulars of coverage, provided they work within minimum federal standards. *See* 42 U.S.C. § 1396a(k)(1); 42 U.S.C. § 1396u-7(b) (providing several options that qualify as "benchmark coverage" or "benchmark-equivalent coverage"). Petitioners correctly note that, beginning in 2014, Medicaid coverage must include certain "essential health benefits." 42 U.S.C. § 1396u-7(b)(5). But again, the "essential health benefits" requirement simply delineates general categories of coverage that must be offered, within which the States can tailor their Medicaid programs as needed. 42 U.S.C. § 18022(b). Indeed, recent guidance from the Department of Health and Human Services has emphasized that States have wide latitude in defining the essential health benefits based on each State's particular needs.[4]

The ACA also continues Medicaid's tradition of cooperative federalism by providing financial assistance to the States to implement the ACA's expansion. Indeed, the federal government will assume 100% of the cost of newly eligible Medicaid enrollees for the first three years of the expansion. 42 U.S.C. § 1396d(y). Although that percentage declines beginning in 2017, the federal government will continue to assume 90% of the cost in 2020 and beyond. *Id.* Even at 90%, the rate significantly exceeds typical federal Medicaid contribution rates, which range from 50% to 83%. *See* 42 U.S.C. § 1396d(b). Petitioners nonetheless complain at length about the supposed increase in State healthcare spending that the ACA will require. Pet. Br. 10, 16. But petitioners' argument is wrong for at least two reasons.

First, petitioners argue that, with the enactment of the ACA, State Medicaid spending will "increase by at least $20 billion" by 2020. Pet. Br. 10. But without measuring that number against the baseline of increased spending *without* the ACA, petitioners' assertion is meaningless. When compared to the baseline of what States would spend without healthcare reform, State spending is expected to increase by only

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[4] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin* (December 16, 2011), *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

1.4% under the ACA's eligibility expansion.[5] At the same time, the percentage of uninsured adults earning less than 133% of the FPL is expected to decrease nationwide by 44.5%.[6]

Second, petitioners complain about the "substantial costs generated by individuals who are *presently eligible for* but not enrolled in Medicaid," because those individuals will now enroll to comply with the minimum-coverage provision. Pet. Br. 16 (emphasis added). In essence, petitioners complain that their costs will increase because the ACA makes Medicaid more *effective* by encouraging and providing access to those who are *already* eligible. But those increased costs have nothing to do with the ACA's Medicaid expansion. Further, by focusing on the supposed costs of increased participation in Medicaid, petitioners ignore the cost savings created by the ACA. For example, increased coverage will lower the cost of uncompensated care, which is forecast to be between $106 billion and $141 billion nationwide by 2019 without healthcare reform.[7]

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[5] Kaiser Comm'n, *supra* note 1, at 10, tbl. 1.

[6] *Id.* Petitioners argue that other estimates show "that increased costs could be as high as . . . $43.2 billion for States." Pet. Br. 10. That estimate assumes an increase in enrollment by individuals currently eligible for Medicaid who have not yet enrolled. But even under that estimate, State spending would increase by only 2.9% over the baseline, with a 69.5% reduction in uninsured adults earning less than 133% of the FPL. Kaiser Comm'n, *supra* note 1, at 11, tbl. 2.

2. The ACA's Medicaid expansion itself is the product of cooperative federalism.

Amici have taken full advantage of Medicaid's cooperative structure, working with the federal government to improve healthcare while crafting individualized programs that address each State's particular needs. One way that States have frequently taken advantage of the program's flexibility is by extending eligibility to additional categories of the poor, beyond the mandatory coverage groups. After individual States have successfully expanded coverage, Congress has often followed their lead by making that expanded coverage mandatory. In that way, the States' experiences shape and inform Congressional adjustments to the program's minimum federal standards.

For example, in 1965, the States could extend coverage to groups such as financially needy children who could not qualify for cash assistance. Health Insurance for the Aged Act, Pub. L. No. 89-97, § 1902, 79 Stat. 344 (1965). Two decades later, Congress amended Medicaid to make coverage of financially needy children mandatory. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4601, 104 Stat. 1388-166 (1990). Similarly, in 1986, Congress expanded the program to allow States the option to cover all pregnant women and infants with income below the FPL—whether they were receiving welfare or not. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401, 100 Stat. 2050 (1986). By 1988, that coverage became mandatory. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 750 (1988). Today, after decades of expansion, participating States are required to extend Medicaid to infants, children under age six, and pregnant women whose family incomes are below 133% of the FPL, as well as to all children 6 to 18 years of age with family incomes up to 100% of the FPL. 42 U.S.C. 1396a(a)(10)(A)(i)(IV), (VI)-(VII), (l)(1)-(2).

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[7] Garrett, *supra* note 2, at 13.

Thus, historically it has been the States, not Congress, that have led the way in expanding eligibility for Medicaid. Medicaid's flexibility has enabled the States to experiment with different approaches to healthcare policy and become the "laborator[ies]" of democracy once envisioned by Justice Brandeis. *See New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). When the States' experiments have demonstrated that extended coverage is effective and practical, then Congress has followed by "raising the floor" to make a wider group of needy people eligible. That is precisely how cooperative federalism should work: Congress first grants the States the flexibility to try alternative approaches, and then adjusts the federal minimum standards based on the States' experiences.

The ACA expansion follows the same pattern. Prior to the adoption of the ACA, a number of States attempted to address the alarming number of uninsured citizens and the lack of affordable insurance by obtaining demonstration waivers and extending Medicaid coverage to low-income, nonelderly, nondisabled adults. For example, in 1997, Massachusetts implemented a Medicaid waiver to expand coverage to children with family incomes up to 200% of the FPL and certain categories of adults with incomes up to 133% of the FPL.[8] Similarly, Vermont expanded Medicaid eligibility to thousands of low-income residents with incomes as high as 185% of the FPL,[9] and to children with family incomes up to 300% of the FPL.[10] When Congress sought to address the national health coverage crisis by expanding coverage to all nonelderly Americans under 133% of the FPL, it was thus following the lead of States such as Massachusetts and Vermont. As with earlier expansions of eligibility, the experiences of individual States helped to shape and inform new federal standards.

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[8] *See* Massachusetts Medicaid Policy Institute, *The MassHealth Waiver: 2009-2011...and Beyond* (Feb. 2009), *available at* http://www.massmedicaid.org/~/media/MMPI/Files/MassHealth%20Waiver%202009%20to%202011%20and%20Beyond.pdf

[9] Kaiser Comm'n on Medicaid and the Uninsured, *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences* 21 (July 2010), *available at* http://www.kff.org/medicaid/upload/8087.pdf

[10] Kaiser Comm'n on Medicaid and the Uninsured, *Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures* 23 (Oct. 2000), *available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13443

Amici have become leaders in healthcare reform by taking advantage of the flexibility in the current Medicaid system and by acting as models to promote changes within the national system. With the enactment of the ACA, amici intend to continue in that role, by both cooperating with the federal government and experimenting with new and individualized ways of improving access to healthcare.

B. Medicaid's eligibility standards are a core element of the program, and Congress may condition continued participation on compliance with those standards.

In changing Medicaid's eligibility standards, Congress made a considered policy choice to expand eligibility to a large population of formerly ineligible individuals and thereby help to lower the increasing number of uninsured Americans. Compliance with the new eligibility standards is thus necessary to carry out the basic goals of the program. For that reason, Congress may condition all Medicaid funding on compliance with those standards without running afoul of the Constitution. Rather than coercing the States into complying with a minor or tangential federal policy, Congress has defined one of the program's core elements.

Where a particular condition is a minor component of a massive program like Medicaid, and the condition is only peripherally related to the program's fundamental goals, threatening to pull *all* program funds for failing to comply with that condition could effectively be coercive. If, for example, Congress conditioned all Medicaid funding on the requirement that a State prohibit physician-assisted suicide, that condition—though tangentially related to the provision of health care—would raise serious concerns. *Cf. Gonzalez v. Oregon,* 546 U.S. 243 (2006).

The converse is also true. If a federal requirement is crucial to effectuating one of Congress's central legislative policies, then it is appropriate for Congress to condition any further participation in the program on a State's compliance. Where noncompliance would frustrate a central policy of the program, a suspension of federal funds or termination from the program is commensurate with the breach. For example, a State would be hard-pressed to complain if the federal government conditioned all highway construction funding on compliance with minimum federal construction standards. In such an instance, Congress is not strong-arming the States; it is defining the basic nature of the program.

Central to the Medicaid program since its inception has been the requirement that, in exchange for federal funds, participating States must agree to extend Medicaid coverage to certain populations identified by Congress. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981) ("As originally enacted, Medicaid required participating States to provide medical assistance to 'categorically needy' individuals who received cash payments under one of four welfare programs established elsewhere in the Act."). The original 1965 Medicaid statute required participating

States to cover the elderly, disabled, and members of families with dependent children and an extremely low income. *Id.* In addition, Congress granted the Secretary the authority to withhold all Medicaid funds from participating States that failed to cover the required population groups or otherwise failed to meet program requirements. 42 U.S.C. § 1396c. Congress also reserved the right unilaterally to amend Medicaid at any time. 42 U.S.C. § 1304.

As described above, Congress has exercised its authority to amend Medicaid by expanding the mandatory coverage groups several times over the last 45 years, thus "raising the floor" of Medicaid. In these instances, Congress has required the States to comply with the expansion and has retained the Secretary's authority to withhold federal funds from participating States that fail to cover the required population groups. The ACA expansion continues the same pattern. Congress has once again redefined the program and "raised the floor" by extending mandatory eligibility.

Yet the ACA expansion is extraordinary in both size and purpose. Under the ACA, all Americans earning up to 133% of the FPL are eligible for Medicaid beginning in 2014. Under conservative estimates, there are expected to be approximately 15 million newly eligible Medicaid enrollees because of the ACA expansion.[11] In Oregon, for example, Medicaid enrollment is projected to increase by 60% to 80% under the ACA.[12]

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[11] Kaiser Comm'n, *supra* note 1, at 37, tbl. 3.

The ACA expansion also represents a major philosophical change in the purpose of the program. Since it was first enacted, Medicaid has been targeted narrowly to groups such as the elderly, the disabled, pregnant women, and children. In that way, the program was an extension of welfare programs that had historically been aimed at alleviating poverty among those perceived to have only a limited ability to fend for themselves. But under the ACA, Medicaid eligibility is extended to *all* Americans who are under 133% of the FPL, including single, childless, able-bodied adults. The expansion thus represents a new policy to address a new concern—namely, a pervasive lack of affordable health coverage.

Petitioners acknowledge that the Medicaid expansion is a "dramatic" change in the program. Pet. Br. 7. Indeed, it is precisely *because* the expansion represents such a significant change that petitioners apparently believe that the federal government cannot compel the States to comply with it. Pet. Br. 7-8, 34-35. But petitioners' reasoning turns cooperative federalism on its head.

Because the Medicaid expansion is crucial to effectuating one of the program's core policies, a State that refused to implement the expansion would frustrate one of the basic goals of the program. Withholding a noncomplying State's Medicaid funding in such a circumstance is an appropriate, measured response, consistent with the principles of cooperative federalism and consistent with the federal government's role of setting the "significant requirements" of a cooperative program. *Schaffer v. Weast*, 546 U.S. 49, 52 (2005). Because the eligibility expansion is a fundamental shift in the program, Congress may permissibly require States to implement the expansion or leave Medicaid.

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[12] *Id.* at 10-11.

Petitioners also complain that, unlike some previous expansions, Congress did not give the States the option of continuing to participate in Medicaid while declining to undertake the expansion. Pet. Br. 10, 39-40. But there are sound policy reasons for Congress not to design the ACA expansion as an opt-in part of the program. First and foremost, the expansion is aimed at addressing a national crisis in the rate of the uninsured and a lack of affordable coverage. To address that problem and increase access to health insurance among the poor, Congress reasonably concluded that all States who want to remain in Medicaid must take part in the expansion.

In addition, by implementing a mandatory, uniform expansion, Congress allowed all participating States to address the problem of the uninsured simultaneously. If Congress made the expansion optional, even States that might favor the idea of expanding the program could potentially be dissuaded from doing so without assurance that other States would follow suit, for fear of putting themselves at an economic disadvantage. *See Steward*, 301 U.S. at 588 (explaining that the Social Security Act addressed the problem of States' unwillingness to create unemployment insurance for fear of putting themselves at economic disadvantage). By uniformly raising the floor of the Medicaid program for all participating States, Congress addressed this problem.

In objecting to the expansion, petitioners are effectively seeking to veto Congress's considered policy choice. When Congress makes a substantial change to the core of a popular program like Medicaid, participating States that are unhappy with the policy change may be forced to make a difficult choice. But the fact that the choice is difficult does not make it unconstitutional.

C. The gradual implementation of the expansion allows States wishing to opt out of Medicaid to do so.

Although withdrawing from a successful and popular program like Medicaid would be difficult, Congress has implemented the expansion in such a way to make it possible. By delaying implementation of the expansion, the ACA allows the States sufficient time to create and implement a replacement system—while continuing to receive federal funds. This lengthy transition period further supports the conclusion that the ACA's Medicaid expansion is not impermissibly coercive.

The eligibility expansion does not go into effect until 2014—nearly four years from the date the bill was signed into law. As a result, "states have plenty of notice . . . to decide whether they will continue to participate in Medicaid by adopting the expansions or not." Pet. App. 62a. In addition, the federal government will fund 100% of the cost of expansion for the first three years. The States could therefore continue to participate in the program until 2017 without significant financial loss. Moreover, a State may also be able to continue to receive Medicaid funding while transitioning into a State-run program by proposing a demonstration project. If the Secretary determined that the project would serve the goals of the Medicaid program, the Secretary could waive some standard Medicaid requirements while continuing to provide federal funding. 42 U.S.C. § 1315(a). In sum, it would be feasible—although perhaps unpopular—for petitioners to opt out of Medicaid rather than comply with the eligibility requirements.

Petitioners misconstrue the ACA in arguing that States cannot give up Medicaid because it provides the only way for needy individuals to comply with the minimum-coverage provision. Nothing in the ACA provides that Medicaid is the only option for needy individuals. In fact, "minimum essential coverage" includes "[s]uch other health benefits coverage . . . as the Secretary of Health and Human Services, in coordination with the Secretary [of the Treasury], recognizes." 26 U.S.C. § 5000A(f)(1)(E). If a State were to withdraw from Medicaid and enact its own program for the needy, such a program could be recognized by the Secretary as providing minimum essential coverage.

In any event, the minimum-coverage provision will not affect most individuals who qualify for Medicaid, because the penalty provisions exempt those who are unable to afford coverage. 26 U.S.C. § 5000A(e).[13] Individuals making less than 133% of the federal poverty level[14] are unlikely to incur a penalty simply because their State chose to withdraw from the Medicaid program.

In sum, although withdrawal from the Medicaid program might be politically unpopular, it remains a viable option for States who do not wish to expand eligibility to individuals earning up to 133% of the federal poverty level. Congress has provided the States with adequate time to plan and implement a new system, as well as a mechanism for withdrawing from Medicaid in an orderly fashion.[15]

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[13] No penalty is imposed on individuals who are not required to file federal income tax returns for the year. 26 U.S.C. § 5000A(e)(2). Further, individuals are exempt from the penalty if their required insurance contributions exceed eight percent of their income or if the Secretary of Health and Human Services determines that they have "suffered a hardship with respect to the capability to obtain coverage under a qualified health plan." 26 U.S.C. § 5000A(e)(1), (5).

[14] The federal poverty level in 2010 was $10,830 for one person and $22,050 for a family of four. 75 Fed. Reg. 45,629 (Aug. 3, 2010).

[15] Petitioners contend that they cannot create a State-funded replacement for Medicaid, because the federal government is already taxing their citizens. Pet. Br. 42-46. But that argument evinces a fundamental misunderstand-

D. Petitioners' theory of coercion is unworkable and contravenes the purpose of federalism.

Petitioners have failed to advance a workable approach to coercion, one that is consistent with federalism and allows for reasonable, practical application both here and in future cases. In particular, petitioners fail to grapple with the consequences of their coercion theory, for Medicaid and for other critical federal-State programs that buttress State efforts to protect the health and welfare of their citizens.

Stripped to its essentials, petitioners' "coercion" argument is this: the funds available under the Medicaid program are so substantial, and the need for healthcare services for the poor so crucial, that no State can decline to participate in Medicaid. But petitioners' emphasis on Medicaid's size is misplaced. The coercion inquiry does not turn on the mere size or success of the federal program; instead, it is a fact-specific inquiry that looks to the design of the overall program and the relationship between the challenged condition, federal funding, and possible sanctions.

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ing of the Spending Clause power and our federalist system. In any case where the federal government exercises its Spending Clause power, a State that refuses to accept federal funds will lose out on money paid by its own citizens. If each State was instead given a different tax rate based on the amount of federal funds it received, we would no longer have a federalist system.

This Court has never suggested that Congress may tackle only small problems under the spending power, rather than large ones that require substantial funding. Nor would such a restriction be advisable. Federal action is often prompted by the kinds of collective action problems that the Court discussed in *Steward*. There, the States were hard-pressed to cope with massive unemployment caused by the nation's long depression. *See* 301 U.S. at 586 (describing unemployment as reaching "unprecedented heights"). Congress responded by providing an incentive for States to adopt unemployment insurance programs, by imposing an unemployment tax on most employers with a tax credit for employers who paid into approved state unemployment insurance programs. *Id.* at 574-75. The unemployment provisions of the Social Security Act were not a minor effort, but a major federal program intended to combat a serious national problem. The Court should not adopt a spending clause restriction that prevents Congress from designing programs that are large enough to be effective.

Likewise, the success of a program, as measured by the participation of the States, is not a basis for deeming the program coercive. This Court rejected that argument in *Dole*, 483 U.S. at 211, and petitioners' effort to resuscitate it here is unpersuasive. Petitioners may be correct that neither they nor the other States will decide to drop out of the Medicaid program in the coming years. But even if that proves true, it is because Medicaid is a valuable and popular program—not because the States are coerced into participating. As this Court held in *Dole,* a federal grant program is not unconstitutional "simply by reason of its success in achieving the congressional objective." *Id.* at 211. Neither the universal participation of the States in Medicaid now, nor their likely participation in the coming years, proves that the program is unconstitutional.[16]

The ramifications of petitioners' theory of coercion would be far-reaching. One consequence of petitioners' argument is certain: if adopted, the Medicaid program will be effectively frozen in time and neither Congress nor the States will be able to adapt this successful, established program to help meet the future health care needs of more low-income Americans. Unmet health care needs, of course, are not static; those unmet needs will continue to grow as health care costs increase, the population ages, and demographic changes (such as the nation's obesity problem) prompt new demands on our national health care system. Under petitioners' theory, however, Medicaid is just too big, and the States' dependency too "entrenched," Pet. Br. 42, for Congress to change the design of the program to meet those needs—even when such changes are democratically adopted and even when the changes are sought by most States.

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[16] For the same reason, petitioners' reliance on the fact that Congress did not anticipate that any State would withdraw from Medicaid is misplaced. Petitioners' extensive discussion of the various provisions of the ACA demonstrates, at most, that Congress believed that the new eligibility expansion would not cause States to withdraw from Medicaid. *See* Pet. Br. 33-39. It would be entirely reasonable for Congress to assume that the States would choose to implement the federally funded expansion and continue participating in Medicaid, which has been successful, popular, and valuable to the States. Congressional recognition of the success of a federal program, much like the success of the program itself, does not render the program unconstitutional.

The unintended consequences of petitioners' theory do not stop there. Every argument that petitioners advance here—the size of the Medicaid program, the States' dependence on federal funding, the need for the benefits and absence of any alternative program, the fact that State residents pay federal taxes that support Medicaid—could be made by a State threatened with termination of Medicaid funding for failure to comply with any of Medicaid's *current* requirements. Under petitioners' theory, in other words, the current Medicaid program should also be deemed unconstitutional. At the very least, petitioners' theory would prevent the federal government from enforcing any current Medicaid requirements.

Along with this uncertainty about the enforceability of current law, petitioners posit a future in which *any* changes to the program must be optional—taking away Congress's constitutional authority to "fix the terms on which it shall disburse federal money to the States." *See New York v. United States*, 505 U.S. 144, 158 (1992) (internal quotation marks omitted). And even that path may not be available to Congress, because according to petitioners, the offer of generous federal funding to support expansion of the program makes the program coercive. *See* Pet. Br. 47 ("the fact that the federal government's inducement is substantial only exacerbates its coerciveness"). In petitioners' view, if Congress proposes a change and offers to fully fund that change, the offer is coercive. After all, if a State rejects the offer, its residents will still pay taxes to fund the change in other States. *See* Pet. Br. 44 (choice is "illusory" so long as State residents are paying federal taxes that fund programs in other States). In short, what petitioners seek is federal funding for Medicaid without meaningful federal constraints on the design of the program, where each State has individual veto power over the design of the "federal" program. But that result is not consistent with either federalism or—even more crucially—fundamental democratic principles.

Although petitioners oppose expanding Medicaid to cover more poor Americans, Congress made a different choice. Many States supported that choice, and advocated through the political process for more federal funding to expand Medicaid. The bargain struck is one that provides enormous benefits for the States: the federal government will cover nearly all the cost of health care for millions of Americans who cannot afford to pay for it on their own. That change will reduce the burden on States to pay for uncompensated health care and improve the health and well-being of their residents. At the same time, States retain flexibility in administering Medicaid and the option to seek waivers under the ACA to experiment with different approaches and respond to local needs. This is emphatically not a case where Congress has "tipped the scales of power" against the States. Pet. Br. 59. Rather, Congress carefully took the interests of the States into account and worked within Medicaid's established and successful framework of cooperative federalism.

III. In any event, the Medicaid expansion is not facially coercive because the Secretary has the discretion to craft an appropriate response where a State fails to comply.

For the reasons explained above, Congress permissibly may expand Medicaid's mandatory eligibility groups and may withhold Medicaid funds from a State that refuses to implement the expansion. But even if Congress could not do so, it does not follow that the ACA's Medicaid expansion is facially unconstitutional. Congress has delegated to the Secretary the discretion to craft an appropriate response for States that do not implement the ACA's Medicaid expansion. Because of that discretion, the law is not facially coercive.

A party who mounts a facial challenge to a statute must demonstrate that the statute cannot operate constitutionally under any circumstance. *See United States v. Salerno*, 481 U.S. 739, 745 (1987) ("A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid."). Petitioners cannot carry that burden here.

Medicaid is a complex program with an extensive list of requirements for States that choose to participate. *See West Virginia v. U.S. Dept. Health and Human Serv.*, 289 F.3d 281, 294 (4th Cir. 2002) (noting that, given Medicaid's complexity, "there are untold ways in which a state plan might fail to comply with the Act and the governing regulations"). To enforce those various requirements, Congress included an enforcement provision, 42 U.S.C. § 1396c. That provision, which has been a part of the law since its inception, authorizes the Secretary of the Department of Health and Human Services to withhold all *or some* of a participating State's Medicaid funds in the event that the State refuses or fails to comply with one of the Act's requirements:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, *in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure*), until the Secretary is satisfied that there will no longer be any such failure to comply. . . .

42 U.S.C. § 1396c (emphasis added).

Pursuant to that provision, if a State were to refuse to implement the Medicaid expansion, the Secretary would, after notice and a hearing, issue an order withholding some or all of the State's Medicaid funding unless and until the State came into compliance. Under the particular circumstances of a given case, the Secretary could decide to withhold all funds from a State that did not comply with the expansion. But Congress has not *required* the Secretary to do so. Instead, Congress has given the Secretary the discretion to determine the appropriate response for States that refuse to comply.

In arguing that the expansion is facially unconstitutional, petitioners *presume* that the Secretary would exercise her discretion by withholding all funds. That may or may not be true, but such a theoretical possibility is insufficient to sustain a facial challenge to the ACA. *Washington State Grange v. Washington State Republican Party*, 552 U.S. 442, 449-50 (2008) ("In determining whether a law is facially invalid, we must be careful not to go beyond the statute's facial requirements and speculate about 'hypothetical' or 'imaginary' cases."). To date, the Secretary has not notified any State that it will lose all Medicaid funds if it fails to comply with the Medicaid expansion. Accordingly, the issue whether the federal government may permissibly do so is not ripe for review.

As noted above, the Secretary could decide to withhold all funds from a State that did not comply with the expansion. But the mere fact that withholding all funds is included among the spectrum of choices committed to the Secretary's discretion does not make the law facially coercive. *See West Virginia*, 289 F.3d at 292-93 (finding that Medicaid provisions were not facially coercive because of the possibility that the State could lose all Medicaid funds if it did not comply).

Medicaid is a complex law that imposes many requirements on States that choose to participate. Rather than attempt to provide a specific enforcement response for any particular breach, Congress made a reasonable—and constitutional—choice to leave this to the Secretary's discretion in the particular circumstances of a given case. Notably, the Secretary has always had discretion under 42 U.S.C. § 1396c to enforce *any* of the myriad conditions of Medicaid by withholding the noncompliant State's Medicaid funds. If the mere fact that the statute provides that the Secretary may withhold all Medicaid funds was enough to make the law unconstitutional, then the Medicaid Act is—and always has been—facially unconstitutional.

In short, this Court is not in a position to conclude that the Medicaid expansion is facially unconstitutional without knowing what the Secretary would do in a particular case. Because the law expressly delegates to the Secretary discretion to determine the appropriate course of action where States fail to implement the expansion, the law is necessarily capable of constitutional application.

CONCLUSION

The ACA's Medicaid expansion is not unconstitutionally coercive. This Court should affirm the judgment as to this issue.

Respectfully submitted,
JOHN R. KROGER
Attorney General of Oregon
ANNA M. JOYCE
Solicitor General
KEITH DUBANEVICH
Chief of Staff

Counsel for *Amicus Curiae*
State of Oregon

AMICUS
CURIAE
BRIEF

No. 11-400

In the
Supreme Court of the United States

STATE OF FLORIDA, et al., *Petitioners*,

v.

DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al., *Respondents*.

On Writ of Certiorari to the U.S. Court of Appeals
for the Eleventh Circuit

BRIEF OF SENATE MAJORITY LEADER HARRY REID, HOUSE DEMOCRATIC LEADER NANCY PELOSI, AND CONGRESSIONAL LEADERS AND LEADERS OF COMMITTEES OF RELEVANT JURISDICTION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS (Medicaid)

PROFESSOR WALTER DELLINGER
1701 18th St. N.W.
Washington, D.C. 20009
(202) 383-5319

CHRISTOPHER J. WRIGHT
Counsel of Record
TIMOTHY J. SIMEONE
MARK D. DAVIS
WILTSHIRE & GRANNIS LLP
1200 18th St. N.W., #1200
Washington, D.C. 20036
cwright@wiltshiregrannis.com
(202) 730-1300

FEBRUARY 17, 2012

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INTEREST OF *AMICI CURIAE*[1]

Amici are Senate Majority Leader Harry Reid, House Democratic Leader Nancy Pelosi, and the following congressional leaders and leaders of the relevant committees of jurisdiction:

Sen. Dick Durbin
(Assistant Majority Leader)

Sen. Charles Schumer
(Conference Vice Chair)

Sen. Patty Murray
(Conference Secretary)

Sen. Max Baucus
(Chair, Committee on Finance)

Sen. Tom Harkin
(Chair, Committee on Health, Education, Labor, and Pensions)

Sen. Patrick Leahy
(Chair, Committee on the Judiciary)

Rep. Steny H. Hoyer
(Democratic Whip)

Rep. James E. Clyburn
(Democratic Assistant Leader)

Rep. John B. Larson
(Chair of Democratic Caucus)

Rep. Xavier Becerra
(Vice Chair of Democratic Caucus)

Rep. John D. Dingell
(Lead Sponsor of House Health Care reform legislation)

Rep. Henry A. Waxman
(Ranking Member, Committee on Energy and Commerce)

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[1] Counsel for all parties have consented to the filing of *amicus* briefs, and their consents are reflected on the docket. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae* or its counsel made a monetary contribution to its preparation or submission.

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(Chair, Committee on Commerce)

Rep. Frank Pallone, Jr.
(Ranking Member, Energy and Commerce Subcommittee on Health)

Rep. Fortney Pete Stark
(Ranking Member, Ways and Means Subcommittee on Health)

Rep. Sander M. Levin
(Ranking Member, Committee on Ways and Means)

Rep. Robert E. Andrews
(Ranking Member, Education and the Workforce Subcommittee on Health, Employment, Labor and Pensions)

Rep. George Miller
(Ranking Member, Education and the Workforce Committee)

Rep. Jerrold Nadler
(Ranking Member, Judiciary Subcommittee on Constitution)

Rep. John Conyers, Jr.
(Ranking Member, Committee on the Judiciary)

Amici file this brief for two reasons. First, as elected Members of Congress, *amici* have a duty to support the Constitution, and in exercise of that duty, they write to defend the constitutionality of the Patient Protection and Affordable Care Act. The Act is a landmark accomplishment of the national Legislature, which brings to fruition a decades-long effort to guarantee comprehensive, affordable, and secure healthcare insurance for all Americans. *Amici* paid careful attention to Supreme Court precedents defining the proper bounds of Congress's constitutional authority and relied upon these established rules in formulating, debating, and voting on the Act. They wish to put before the Court their views on why the Act is a valid exercise of Congress's Article I powers.

Second, *amici* believe that the legal theories advanced by the Act's challengers, if embraced by the courts, would seriously undermine Congress's constitutional authority and its practical ability to address pressing national problems. Congress regularly relies on its enumerated powers to protect American consumers and workers, to keep families safe, and to ensure civil rights. *Amici* take seriously their oath to "support and defend the Constitution of the United States," and write in their constitutional role as Members of a coequal branch of government.

INTRODUCTION AND SUMMARY OF ARGUMENT

Congress enacted the Patient Protection and Affordable Care Act ("the Act" or "ACA") in response to a national crisis—over 50 million Americans are currently without healthcare insurance. Congress believed that without a policy response at the federal level, this crisis would only deepen.

But, of course, opinions diverged sharply both within Congress and across the country about the precise nature of the proper policy response to this problem. The process of enacting the ACA reflected those disagreements. For fourteen months, Congress debated, refined, revised, and debated again the ACA and the policy judgments that it embodies. In the end, however, the ACA was adopted by a majority of the House of Representatives and a supermajority of the Senate, and was signed by the President. The opponents of the congressional policies embodied in the ACA now ask this Court to reverse the result of the democratic process and put the nation back on a path toward an ever-growing number of uninsured Americans.

A major policy judgment made by Congress in passing the Act was that Medicaid should be part of the solution to the crisis of the uninsured. For forty-five years, the nation has relied on Medicaid to provide coverage for healthcare and long-term-care services to low-income Americans. Through the Medicaid program, Congress has made available billions of dollars in financial assistance to the States that choose to participate, while conditioning receipt of those funds on compliance with certain requirements regarding eligibility, benefits, provider payment, and administration. Within those requirements, participating States have substantial discretion to design and administer their programs. Congress has also given participating States the ability to cover certain optional populations and offer certain optional benefits with the assistance of federal funds. This programmatic flexibility has resulted in considerable variation in Medicaid programs from State to State.

More specifically, while preserving many choices open to the States, the ACA expands Medicaid eligibility by requiring that the States extend benefits to individuals under the age of 65 with incomes below 133 percent of the federal poverty level. ACA § 2001(a)(1). Medicaid currently extends eligibility to many but not all groups of people below this income threshold, and an estimated 16 million additional Americans will qualify for Medicaid as a result of the ACA's expansion. Congress also specified that a certain level of medical care and services must be offered, *i.e.*, a "benchmark" plan with at least the essential health benefits required of plans to be sold in individual and small-group insurance markets. *Id.* § 2001(a)(2).

Significantly, unlike past Medicaid expansions—where the federal medical assistance percentage for some States was as low as 50 percent—the federal government will reimburse many States for 100 percent of the costs of the benefits paid on behalf of those made eligible by the ACA from their effective date in 2014 through 2016. *Id.* § 2001(a)(3)(B); Health Care and Education Reconciliation Act of 2010 ("HCERA") § 1201.[2] That percentage will gradually decrease—to 95 percent in 2017, 94 percent in 2018, and 93 percent in 2019—and eventually level off for all States at 90 percent in perpetuity. ACA § 2001(a)(3)(B). These percentages have almost no precedent in Medicaid policy; the costs of services to almost all currently eligible populations are matched at an average rate of 57 percent. Andy Schneider and David Rousseau, *Medicaid Resource Book* ch. III at 82 (Kaiser Commission on Medicaid and the Uninsured July 2002).[3]

One fundamental aspect of Medicaid that Congress did *not* change in adopting the ACA is that State participation in the program remains, as it has always been, entirely voluntary. Provider participation and individual participation in the program likewise remain entirely voluntary.

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[2] Certain States that expanded Medicaid coverage to this population prior to the enactment of the ACA will receive less than the 100 percent federal match in the initial years but will receive the 90 percent match in the long run. *See* 42 U.S.C. § 1396d(z).

[3] *Available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=14261.

Notwithstanding the voluntary nature of Medicaid, Congress expected that all of the States would choose to continue participating in the program under the ACA. The problems posed by an enormous population of uninsured individuals affect state and local governments acutely—for example, state and local governments often bear much of the financial burden of uncompensated care. And because the federal government ultimately will reimburse 90 percent of the costs of benefits paid on behalf of beneficiaries newly eligible under the ACA, the Act offers the States a way to address the growing crisis of uninsured citizens while bearing only a relatively small percentage of the cost. Therefore, Congress anticipated that the States would continue to participate in Medicaid because of the tremendous fiscal advantages that the program confers upon them.

Indeed, credible projections indicate that the Medicaid expansion will, on balance, *help* state budgets because any increase in state spending under Medicaid will be more than offset by new savings under the Act. Those savings will include savings on (1) state-funded programs serving people who will be newly Medicaid-eligible; (2) state-funded programs for those who will be eligible for subsidized coverage on the healthcare exchanges established by the Act; (3) state-funded high-risk pools whose beneficiaries will become eligible for coverage through the exchanges; and (4) premiums paid by state and local employers for group health coverage for their employees, on account of reduced cost-shifting of the costs of uncompensated care to group health plans.

In passing the ACA, Congress was well aware that the political leadership in some States objects to healthcare reform as a policy matter, and specifically to using Medicaid to expand coverage. Through the legislative process, Congress heard those States' objections loud and clear—and repeatedly. But in the end, Congress rejected them while accommodating the States' fiscal concerns with unprecedentedly generous federal funding for the newly eligible population. And, of course, as previously noted, while Congress *expected* that the States would remain in the Medicaid program because of its fiscal advantages, Congress did not *require* such participation, but rather retained the bedrock principle of voluntary state participation.

In debating and ultimately adopting the ACA, Congress had no reason to expect that anything in the Constitution barred elected federal officials from making a policy judgment to expand coverage under Medicaid—which Congress had previously expanded repeatedly over the years. Indeed, even the challengers do not dispute that as a general matter Congress may, under the Spending Clause, "fix the terms on which it shall disburse federal money to the States," *New York v. United States*, 505 U.S. 144, 158 (1992), and also may "condition[] receipt of federal moneys upon compliance ... with federal statutory and administrative directives," *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). Nor do the challengers dispute that the Act's amendments to Medicaid satisfy the four well established restrictions on

Congress's spending power set forth by this Court in *Dole*. *See id.* at 207-10. Instead, the challengers' novel "coercion" theory—*never* previously applied by *any* court to invalidate an act of Congress—depends entirely on the claim that even though the States' participation in Medicaid remains entirely voluntary under the ACA, in practice they have no choice but to participate.

This Court should reject the challengers' arguments for multiple reasons. First, it would be a mistake even to accept the existence of a so-called "coercion doctrine." Such a doctrine would necessarily drag federal judges into policy debates that ought not be addressed in litigation because attempting to draw a line between permissible persuasion and impermissible coercion would inevitably raise political questions that ought not be resolved by the courts. Relatedly, even attempting to make such distinctions would require the courts to resolve intractable factual questions that vary from State to State as a result of different policy choices made by different state governments about how much healthcare to provide and how to pay for it. And a court-enforced coercion doctrine would also usurp Congress's core role as the entity elected by citizens to make difficult policy decisions. For these reasons, *amici* urge the Court, as a threshold matter, to decline to adopt a "coercion doctrine."

Second, even if the Court accepts some version of a "coercion doctrine," it should not adopt any form of the doctrine that would support the challengers' claim here. The challengers are factually incorrect that the States have "no choice" but to remain with the Medicaid program, and logically incorrect that

Congress's failure to provide for the eventuality that a State might drop out means that Congress understood the States to have no choice. In reality, what Congress understood is that a program whereby the States can address the health-insurance needs of their poorest citizens with a State's expenditures ultimately limited to 10 percent of the total cost of such coverage, is such a good deal that the States are exceedingly unlikely to turn it down. But again, they are certainly entitled to do so if they wish—Medicaid participation remains completely voluntary.

Finally, accepting the challengers' coercion arguments here could have far-reaching unintended consequences. A decision in the challengers' favor might, for example, call into question prior expansions of healthcare coverage through the Medicaid program. It might also call into question other federal programs, because Congress routinely conditions the receipt of federal funding on the States' agreement to fulfill congressional requirements. And such a decision would make it difficult for Congress to legislate going forward, while also harming the States by making Congress less able to adopt programs that would provide financial assistance to the States.

ARGUMENT

I. THE COURT SHOULD NOT ADOPT ANY FORM OF A COERCION DOCTRINE.

The heart of the challengers' objection to the ACA's expansion of Medicaid is that it allegedly exceeds Congress's power under the Spending Clause because "Congress may not exercise its spending power coercively." Pet. Br. 29. But the challengers do not even attempt to articulate a standard that would allow the courts to distinguish impermissible coercion from permissible persuasion; to the contrary, they acknowledge that "the line between coercion and persuasion" is not "bright." *Id.* at 30.

While correct so far as it goes, that concession is a dramatic understatement. As discussed below, requiring the federal courts to attempt to distinguish between persuasion and coercion in the context of the spending power would be unworkable. But, for fundamental reasons, it would also be undesirable. First, the challengers' arguments would drag the judiciary into a thicket of political judgments and quasi-factual determinations that are not suitable for resolution through litigation. And the challengers' approach would simultaneously take those decisions *away* from the officials who are elected to make them. These problems strongly counsel against enshrining a coercion doctrine in the law.

A. The Challengers' Coercion Arguments Lack Judicially Administrable Standards and Raise Fundamentally Political Issues.

In assessing the challengers' arguments, it is important to recognize that there are four judicially enforceable limitations on Congress's spending power. First, those conditions must promote the general welfare. *Dole*, 483 U.S. at 207. Second, conditions on receipt of federal funds must be reasonably related to the legislation's stated goal. *Id.* Third, such conditions must reflect Congress's unambiguous intent to condition funds on a particular action by the States as to which they may knowingly choose. *Id.* And finally, conditions on federal funds may not violate other provisions of the Constitution. *Id.* As the Eleventh Circuit found, the challengers "do not contend the Act's Medicaid expansion violates any of these restrictions." Pet. App. 53a.[4]

1. *Steward Machine* and *Dole* did not establish a coercion doctrine.

Rather than relying on these long-standing limitations, the challengers incorrectly argue that this Court "has long recognized that an exercise of Congress' spending power would violate the Constitution if it were 'so coercive as to pass the point at which "pressure turns into compulsion."'" Pet. Br. 27 (quoting *Dole*, 483 U.S. at 211, in turn quoting *Steward Machine v. Davis*, 301 U.S. 548, 590 (1937)). But the challengers dramatically overread *Dole* and *Steward Machine*, which do no more than allude to the *possibility* that legislation could conceivably be so coercive as to be constitutionally impermissible. And the challengers do not even attempt to articulate judicially enforceable standards for a coercion test, essentially conceding that such an analysis would be an inherently political one.

The decisions of this Court upon which the challengers rely reflect concerns about both the judicial administrability of a coercion doctrine and its inherently political nature. Indeed, the opinion of the Court in *Steward Machine*—in which this Court first suggested (in a single sentence) the possibility of a coercion analysis—carefully prefaced that suggestion with the caveat "*if we assume* that such a concept can ever be applied with fitness to the relations between state and nation." 301 U.S. at 590 (emphasis added). *Steward Machine* also expressly cautioned that entrusting the courts to police the line between "pressure" and "coercion" might be unmanageable. This Court correctly observed that every federal spending statute "is in some measure a temptation," and "to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." *Id.* at 589-90.

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[4] All citations to the Petitioner's Appendix are to the appendix to the federal government's petition for certiorari in *U.S. Department of Health and Human Services v. Florida*, No. 11-398.

The D.C. Circuit examined this language of *Steward Machine* more than thirty years ago in a case—like this one—questioning new funding conditions imposed by amendments to Medicaid. *See Oklahoma v. Schweiker*, 655 F.2d 401 (D.C. Cir. 1981). *Schweiker* understood *Steward Machine* as "admonish[ing]" that "courts should attempt to avoid becoming entangled in ascertaining the point at which federal inducement to comply with a condition becomes a compulsion." 655 F.2d at 413. The D.C. Circuit further observed that Justice Cardozo's opinion "wis[ely]" recognized that "[t]he courts are not suited to evaluating whether the states are faced ... with an offer they cannot refuse or merely a hard choice." *Id.* at 414. There is, in short, nothing in *Steward Machine* to support the challengers' claim that this Court "has long recognized" a coercion doctrine. Pet. Br. 27.

Nor does the challengers' coercion theory find support in this Court's decision in *Dole*. Quoting *Steward Machine*, the *Dole* Court did note that "in some circumstances the financial inducement offered by Congress *might* be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Dole*, 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 590) (emphasis added). But *Dole* also quoted *Steward Machine*'s warning that every federal spending statute is in "some measure a temptation" and that equating motive or temptation with "coercion [would] plunge the law into endless difficulties." 483 U.S. at 211 (quoting *Steward Machine*, 301 U.S. at 589-90). *Dole* thus goes no further than *Steward Machine* toward adopting a coercion doctrine that this Court has acknowledged would likely defy judicial administration.

2. A coercion doctrine would be standardless and unworkable.

As courts and commentators have observed, developing enforceable coercion standards would be difficult or impossible. Professor Chemerinsky stated bluntly: "The Court ... should not attempt to enforce such a [coercion] limit on the spending power." *Protecting the Spending Power*, 4 Chap. L. Rev. 89, 102 (2001) ("*Spending Power*"). He explained that it is "impossible to draw a line between inducement and compulsion," and that "[a]ll conditions on financial aid from Congress to the states are meant to be an inducement." *Id.* Moreover, employing the term "coercion" in the way the challengers do here "obscures the distinction between a difficult choice and compulsion." *Id.* at 103. Professor Chemerinsky concluded that the States "may have to make a hard decision in foregoing federal funds," but under the "spending power ... states always retain a choice, unpleasant as it may be to give up the federal funds." *Id.*

Professor Sullivan's careful analysis in *Unconstitutional Conditions*, 102 Harv. L. Rev. 1413, 1428 (1989), explained *why* it is "impossible to draw a line between inducement and coercion." *Spending Power*, 4 Chap. L. Rev. at 102. According to Professor Sullivan, *any* attempt to reduce "coercion" to an empirical account is logically doomed to fail because *any* conception of coercion is "irreducibly normative." 102 Harv. L. Rev. at 1428. At root, "[c]oercion is a judgment" about whether potential beneficiaries of federal spending are, as a result of the conditions attached, "worse off with respect to a benefit than they *ought* to be." *Id.* at 1450 (emphasis in original). The clear implication of Professor Sullivan's argument is that allowing—to say nothing of requiring—the judiciary to make judgments about whether States are worse off than they *ought* to be as a result of conditions on federal benefits invites judges to make political decisions.

The Ninth Circuit's decision in *Nevada v. Skinner*, 884 F.2d 445 (9th Cir. 1989), explored in detail the difficulty of establishing standards for judicial enforcement of a coercion test. Nevada argued that withholding all federal highway funds—approximately 95 percent of the State's total highway budget—from the State for failure to comply with the federal speed limit violated a purported "coercion" limitation on Congress's spending power. The Ninth Circuit noted that Nevada had "not given us any principled definition" of the term "coercion," and "our own inquiry has left us with only a series of unanswered questions." *Id.* at 448.

Some of those questions, the Ninth Circuit found, concern how heavily to weigh the loss of federal funds in a coercion analysis:

> Does the relevant inquiry turn on how high a percentage of the total programmatic funds is lost when federal aid is cut-off? Or does it turn ... on what percentage of the federal share is withheld? Or on what percentage of the state's total income would be required to replace those funds? Or on the extent to which alternative private, state, or federal sources of ... funding are available?

Id. And other questions, the court continued, are even "more fundamental" because they involve how to weigh the States' own choices as sovereign entities in the analysis:

> [S]hould the fact that Nevada, unlike most states, fails to impose a state income tax on its residents play a part in our analysis? Or, to put the question more basically, can a sovereign state which is always free to increase its tax revenues ever be coerced by the withholding of federal funds—or is the state merely presented with hard political choices?

Id.

The Ninth Circuit concluded that a coercion doctrine would be "highly suspect as a method for resolving disputes between federal and state governments" given the "difficulty if not impropriety of making judicial judgments regarding a state's financial capabilities." *Id.*

The Ninth Circuit also correctly found support for its rejection of a coercion doctrine in this Court's decision in *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985). Although *Garcia* was not a Spending Clause case, it arose in a related Tenth Amendment context and strongly suggests that rules or doctrines purporting to require federal judges to draw Tenth Amendment lines that simply cannot be drawn with any intellectual consistency—such as what government functions are "traditional" or integral"—should be rejected. The Court in *Garcia* also concluded that, under the Commerce Clause, the "fundamental limitation that the constitutional scheme imposes ... to protect the 'States as States'" inheres "in the workings of the National Government itself." *Id.* at 552-54.

The same should be true here. Rather than require courts to make political choices, reliance should be placed on the safeguards built into our federal system, such as the States' "indirect influence over the House of Representatives and the Presidency by their control of electoral qualifications and their role in Presidential elections," and their "more direct influence in the Senate, where each State received equal representation," which is "underscored by the prohibition of any constitutional amendment divesting a State of equal representation without the State's consent." *Id.* at 551. "In short," the *Garcia* Court concluded, "State sovereign interests ... are more properly protected by procedural safeguards inherent in the structure of the federal system than by judicially created limitations on federal power." *Id.* at 552.

B. A Coercion Doctrine Would Require the Courts to Resolve Difficult Policy Questions.

The problems with judicial administration of a coercion doctrine go beyond the impracticality (or impossibility) of drawing a principled line between persuasion and coercion. The kinds of questions identified by the Ninth Circuit in *Nevada v. Skinner*, *see supra* at I.A.2., implicate specific factual inquiries—*e.g.*, the size of the federal grant at issue, the percentage of the state program represented by those federal funds, and the percentage of state revenues that the federal grant represents. The answers to these questions will be different for different States. In other words, as the D.C. Circuit pointed out in *Schweiker*, in connection with a nationwide program like Medicaid "[e]ven a rough assessment of the degree of temptation [versus coercion] would require extensive and complex factual inquiries on a state-by-state basis." *Schweiker*, 655 F.2d at 414. This could lead to bizarre holdings that the same law was unconstitutionally coercive in some States but not others.

Using the three factors identified in the paragraph above as examples, the government pointed out the wide state-by-state variations to the Florida district court:

> With respect to the first [factor], in fiscal year 2008, federal Medicaid grants ranged from $246 million (Wyoming) to $23.8 billion (New York)—nearly a 100-fold difference.... [With respect to the second] ... the proportion of state Medicaid

> expenditures funded by federal dollars ranged from 50 percent (several states, including Colorado) to 76 percent (Mississippi).... And third, state spending on Medicaid, as a proportion of total state revenues, ranged from 8.4 percent (Alaska) to 34.5 percent (Missouri)—meaning that the proportion of total state revenues formed by federal Medicaid grants ranged from 4.4 percent (Alaska) to 21.5 percent (Missouri).

Memorandum in Support of Defendants' Motion for Summary Judgment, Docket. No. 82, at 45 (Nov. 4, 2010) ("Gov't Mem. re SJ"). As the government concluded, "the benefits and obligations of Medicaid participation affect states in quite different ways," and thus "a conditional spending program might be 'coercive' to one state, but not to another—its fate hanging only on which state chose to sue." *Id.*

Moreover, the different factual situations in different States *result* from different policy choices made by the States about how much healthcare to provide and how to fund those services. Not only have certain States elected to spend more than others on Medicaid, but, of course, different States make different policy choices about how much to spend on everything from education to prisons. And different States fund their state expenditures (including healthcare) differently. For example, six of the States in the challenger group have no personal income tax. That may be sound policy, but it does raise doubts about whether "a sovereign state which is always free to increase its tax revenues [can] ever be coerced by the withholding of federal funds."

Nevada, 884 F.2d at 448. Clearly, then, taking the results of detailed, state-specific factual inquiries and balancing whether the benefits of a federal grant are outweighed by the strings attached would lead the courts into "questions of policy and politics that range beyond [the courts'] normal expertise." *Id.*

In sum, the question whether a State can—as a practical matter, given the particular background facts specific to that State—refuse federal funding quickly becomes a classic political question that hinges on policy priorities of elected state officials and the views of its electorate. *Amici* urge that the federal courts should not be in the business of making such evaluations.

II. UNDER A COERCION ANALYSIS, THE REQUIREMENTS AT ISSUE ARE WELL WITHIN CONGRESS'S POWER UNDER THE SPENDING CLAUSE.

Putting aside the inherent problems with judicial administration of any form of a coercion doctrine, the ACA should not be invalid under any reasonable form of a coercion doctrine that might be adopted.

A. The ACA Does Not Change the Basic Structure of Medicaid Funding, Which Has Never Been Found to Be Coercive.

Congress has always required States that wish to participate in Medicaid to adopt state Medicaid plans that comply with numerous conditions set by Congress. Among these conditions, States have always been required to cover certain categories of Americans, and they have always had to cover certain minimum medical services. *See* 42 U.S.C. § 1396a. If a State fails to adopt such a plan, it has always been ineligible for Medicaid funding, *see id.* §1396b(a), and if it changes its plan or fails to amend its plan to meet new federal conditions, the federal government has always retained discretion to cut off either some or all of that State's Medicaid funding. *See id.* § 1396c; 42 C.F.R. § 430.12(c)(1)(i).

The ACA does not change this basic structure; it simply adds to the already long list of what must be included in a State's Medicaid plan. *See* ACA § 2001(a) (amending 42 U.S.C. § 1396a). To the already long list of groups that must be covered under a State's Medicaid program, the amendment adds another group: nonelderly adults with income at or below 133 percent of the poverty line who were not already covered. ACA § 2001(a). These new conditions are analytically indistinguishable from the conditions previously contained in Section 1396a.

Nor is this the first time that Congress has chosen to expand the conditions of Medicaid participation. *See* 42 U.S.C. § 1396a Notes (listing numerous amendments). Congress has repeatedly amended the conditions of Medicaid participation—often by changing coverage that had been provided voluntarily by the States into minimum conditions of participation. *See infra* § III.A; John D. Klemm, *Medicaid Spending: A Brief History*, 22 Health Care Financing Review 105, 108 (Fall 2000) ("*Medicaid Spending*") (Congress embarked on "a series of Medicaid expansions" that "affected nearly the entire spectrum of Medicaid enrollees." Although these expansions were initially voluntary, "most of the options were converted by subsequent legislation into mandates."). Moreover, no court has ever found one of Congress's prior Medicaid funding conditions to be coercive.

The challengers assert that the ACA is different from prior Medicaid expansions because Medicaid has grown larger over time. Pet. Br. 23. But merely pointing out that the States conditionally receive large amounts of money through Medicaid does not show that participation in the program is coerced. Were this true, *every* condition listed in 42 U.S.C. § 1396a—not merely those added by the ACA—would be coercive. Indeed, such a vast view of coercion would mean that once a federal grant program becomes large enough, Congress could *never* impose conditions on participation in the program.

Not surprisingly, the challengers' expansive view of coercion is not consistent with the decisions of the lower courts, which have repeatedly emphasized that the sorts of garden-variety funding conditions at issue here are not coercive. The challengers characterize the conditions imposed on Medicaid funding as coercive simply because refusing Medicaid funds would strain state budgets and force state legislators to make difficult decisions. But the courts of appeals have consistently held that conditions on federal funding are not coercive simply because they impose "politically painful" choices, *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000), or because a State's decision to decline federal funding would have "fiscal and possibly political ramifications for state officials," *A.W. v. Jersey City Public Schools*, 341 F.3d 234, 244 (3d Cir. 2003).

One reason is that States may always choose to decrease expenditures on other programs or to raise revenues. These alternatives ensure that the States have a real choice to decline even large offers of federal aid. For this reason, the difficulties that accompany a decision to decline federal funding are merely part of the "ordinary *quid pro quo* that the Supreme Court has repeatedly approved." *Jim C.*, 235 F.3d at 1081. As a result, the courts have almost universally recognized that ordinary spending conditions like the ones at issue here simply do not implicate the coercion doctrine. *See, e.g.*, *California v. United States*, 104 F.3d 1086 (9th Cir. 1997) ("The *Dole* court concluded, however, that it would only find Congress' use of its spending power impermissibly coercive, if ever, in the most extraordinary circumstances.").

B. The ACA Is Not Coercive Even Under the Fourth Circuit's Standard.

In light of the numerous cases upholding the conditions that Congress has placed on Medicaid as well as those imposed on other large federal grants, the challengers apparently recognize that they cannot prevail under the standards applied by every circuit other than the Fourth Circuit. *See* Pet. 14 (claiming that the coercion doctrine "has been largely ignored and even expressly rejected by multiple courts of appeals"). As a result, they ask this Court to adopt the approach espoused in dictum by a plurality of the Fourth Circuit in *Va. Dept. of Education v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997) (*en banc*), which they claim is broader than the standard used in other circuits. Pet. 19 (commending the Fourth Circuit's approach in *Riley*). Although the Fourth Circuit has subsequently emphasized that *Riley*'s discussion of coercion is not even binding precedent in that circuit, *West Virginia v. HHS*, 289

F.3d 281, 291 (4th Cir. 2002), it bears emphasis that the ACA meets even the supposedly more demanding standard articulated in *Riley*.

In the *Riley* plurality opinion, Judge Luttig stated in dictum that a serious Tenth Amendment issue would be presented if Congress were to "withhold[] the entirety of a substantial federal grant on the ground that the States refuse to fulfill their federal obligation in some insubstantial respect rather than submit to the policy dictates of Washington in a matter peculiarly within their powers as sovereign States." 106 F.3d at 570. Thus, to meet the standard articulated by Judge Luttig, the challengers would need to show that the conditions imposed by the ACA are *insubstantial* and that the federal government has withheld *all* of their Medicaid funding for failing to meet these insubstantial conditions. But, of course, neither of these statements is true. The obligation to expand coverage is not insubstantial, as challengers apparently demonstrate by arguing that the expansion is too onerous. Indeed, near-universal coverage for the poor is now an important part of Medicaid as Congress has designed it.

In addition, Congress did not condition all of a State's federal funding on compliance with the ACA's Medicaid expansion. In fact, as the Eleventh Circuit correctly noted, Congress did not even condition a State's entire *Medicaid funding* on compliance with the expansion. Rather—consistent with the funding structure it has always used—Congress provided that if a State fails to amend its plan to comply with the expanded-coverage requirements, HHS has discretion *either* to discontinue all of that State's

Medicaid funding *or* to discontinue a lesser portion. 42 U.S.C. § 1396c.

Only a few years after *Riley*, the Fourth Circuit itself confirmed that Medicaid's conditional-funding structure does not amount to coercion, even under the Fourth Circuit's supposedly broader standard. In *West Virginia v. HHS*, West Virginia challenged a 1993 amendment to the Medicaid Act that required States to "recover certain Medicaid costs from the estates of certain deceased beneficiaries," whereas these recovery programs had previously been optional. 289 F.3d at 284. As with the ACA, Congress imposed the requirement by mandating its inclusion in the Medicaid plans that the States submit to the U.S. Department of Health and Human Services. *See* 42 U.S.C. § 1396p(b). West Virginia argued that the new condition was coercive because it conditioned a State's entire Medicaid budget on its compliance with a relatively minor condition, which required West Virginia to recover "approximately two-tenths of one-percent of the more than $1 billion in Medicaid funds received by the state each year." *West Virginia*, 289 F.3d at 285. But the Fourth Circuit found that the new condition was not coercive because, contrary to West Virginia's assertion, the Medicaid Act did not require the Secretary of HHS to withhold *all* of the Medicaid funding of a State that violates the conditions of Medicaid participation. *Id.* at 291-92. Rather, the Medicaid Act gave the Secretary of HHS discretion to withhold either all *or* a smaller amount of the State's Medicaid funding. *See* 42 U.S.C. § 1396c (noting that if a State fails to administer its Medicaid program in accordance with its plan, "the Secretary shall notify such State agency that further payments will not be made to the

State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure)"); 42 C.F.R. § 430.12(c)(1)(i) (requiring every state plan to provide that it will be amended whenever necessary to comply with changes in federal law). The Fourth Circuit found this point to be dispositive. *West Virginia,* 289 F.3d at 292.

As the Eleventh Circuit properly noted, the same reasoning disposes of this case. Pet. App. 62a. The ACA does not require the federal government to discontinue all Medicaid funding to a State that fails to carry out the ACA's mandate to expand Medicaid coverage. Rather, the ACA requires the States to amend their Medicaid plans to comply with new requirements of federal law—including the ACA. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII); 42 C.F.R. § 430.12(c)(1)(i). If a State fails to comply, the statute allows the Secretary of HHS the discretion either to discontinue Medicaid payments or to determine that "payments will be limited to categories under or parts of the State plan not affected" by the breach of the Medicaid conditions. 42 U.S.C. § 1396c(2). Thus, it would be well within HHS's discretion to discontinue merely a portion of a State's Medicaid funding.

In the view of the *amici,* no test such as the one proposed by Judge Luttig should be adopted. Rather, Congress should be free to condition participation in a federal program on compliance with the terms of the federal program. But it bears note that the ACA would pass muster under the most restrictive reading of the Spending Clause proposed by a federal judge.

C. The Eleventh Circuit Correctly Found that the ACA Is Not Coercive.

There are other reasons to conclude that the ACA is not coercive. The Eleventh Circuit discussed four of them, each of which was correct.

First, as the Eleventh Circuit noted, Congress made clear when it began Medicaid that it reserved the right to change the program. *See* Pet. App. 60a-61a (citing 42 U.S.C. § 1304). The challengers quibble with this analysis under the theory that this analysis "confuses foreseeability and coercion." Pet. Br. 41. But foreseeability is highly relevant to the analysis. The challengers have always known that Congress could change even the basic structure of Medicaid at any time. This possibility of changes in funding conditions was part of the bargain that the States voluntarily accepted when they initially chose to accept federal Medicaid funding.

Second, as also noted by the Eleventh Circuit, the federal government will pay for nearly all of the expansion. Pet. App. 61a. Unlike past Medicaid expansions—where the federal medical assistance percentage for some States was as low as 50 percent—the federal government will ultimately reimburse States for 90 percent of the benefits paid on behalf of individuals made eligible by the expanded coverage requirements. ACA § 2001(a)(3)(B); HCERA § 1201. In addition, the ACA will actually reduce the States' costs of caring for the uninsured—between $92 and $129 billion from 2014 to 2019 alone. *See* Matthew Buettgens *et al.*, *Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less*

With the ACA than Without It from 2014 to 2019 (Urban Institute July 2011).[5]

The challengers ask the Court to disregard these benefits, claiming that this Court should focus only on the amount of money the States stand to lose if they opt out of Medicaid. But the Eleventh Circuit squarely addressed why the ACA's 90-percent reimbursement rate is relevant to the coercion analysis: the challengers have argued that the ACA coerces them to spend more money in an endless cycle that will eventually break state budgets. But as the Eleventh Circuit explained, "If states bear little of the cost of expansion, the idea that states are being coerced into spending money in an ever-growing program seems to us to be 'more rhetoric than fact.'" Pet. App. 61a-62a.

Third, the challengers "have plenty of notice—nearly four years from the date the bill was signed into law—to decide whether they will continue to participate in Medicaid by adopting the expansions or not." *Id.* The challengers can hardly say that anything about the bill's timing has prevented them from making alternative arrangements if they wish to drop out of Medicaid.

Finally, the States have the alternative to decrease spending on other programs, raise revenue, or simply reduce the level of healthcare coverage for low-income people in the State if they wish to decline federal funding. Pet. App. 62a. Although this fact would seem to be indisputable and several other circuits have relied on it in rejecting coercion claims,

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[5] *Available at* http://www.urban.org/UploadedPDF/412361-consider-savings.pdf.

see Jersey City Public Schools, 341 F.3d at 243-44; *Pace v. Bogalusa City School Board*,, 403 F.3d 272, 278 (5th Cir. 2005), the challengers claim—somewhat astoundingly given that several of the challengers have no personal income tax and that many of the challengers have among the lowest tax burdens in the country, *see* Gov't Mem. re SJ at 46—that they actually have no power to raise alternative sources of Medicaid funding. Their justification for this claim boils down to a mere policy preference: the challengers do not wish to cut other programs or increase state tax rates. Pet. Br. 44. While there is always room for differences of opinion about whether programs should be cut, revenues should be raised, or healthcare coverage should be reduced in the State, there can be no dispute that resolving this issue is a political question and not a proper matter for judicial resolution. The challengers do not even attempt to show that they *cannot* cut other programs or raise taxes; they merely assert that they do not wish to do so. This is precisely the sort of "hard choice" that the courts have routinely found not to be coercive.

D. The States' Own Actions Indicate That They Have a Genuine Choice Whether to Participate in Medicaid.

In addition to the reasons articulated by the Eleventh Circuit, the challengers' coercion argument also rings hollow in light of the debates that have raged in several of the challengers' States about whether it might even be a *good policy* to decline Medicaid funds. Spurred in part by a Heritage Foundation report that erroneously concluded that the States would save a trillion dollars by dropping out of Medicaid,[6] officials in a number of States began to actively support dropping out of Medicaid. For example, in Florida, State Senator Joe Negron—the "lead author of a proposal to overhaul the state Medicaid program"—told reporters only a year ago that "'[i]f the federal government elects not to allow us to manage the [Medicaid] program the way we believe is in Florida's best interests, then we'll operate our Medicaid program with our resources.'" *Florida Might Try to Withdraw from Medicaid*, Florida Times Union (Feb. 16, 2011).[7] Nor did Senator Negron believe that the large amount of federal funding at stake would stop Florida from making a free decision about whether to drop out: "Negron said the state would use its own portion of projected Medicaid spending to provide what benefits it could, giving priority to 'those on Medicaid that we believe are the most vulnerable and need the most assistance from us.'" *Id.*

Florida is not alone. As the Wall Street Journal reported in November 2010, "Elected and appointed officials in nearly a half-dozen states, including Washington, Texas and South Carolina, have publicly thrown out the idea" of "dropping out of the Medicaid insurance program for the poor." Janet Adamy and Neil King Jr., *Some States Weigh Unthinkable Option: Ending Medicaid*, Wall St. J.

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[6] *See* Dennis Smith and Edmund Haislmaier, *Medicaid Meltdown: Dropping Medicaid Could Save States $1 Trillion* (Heritage Foundation 2009), *available at* http://www.heritage.org/research/reports/2009/11/medicaid-meltdown-dropping-medicaid-could-save-states-1-trillion.

[7] *Available at* http://jacksonville.com/news/florida/2011-02-16/story/florida-might-try-withdraw-medicaid.

(Nov. 22, 2010).[8] Although experts characterized the proposal as "so extreme that even proponents don't expect any state will follow through," that does not change the fact that refusing Medicaid funding is a real option that a number of States have actively considered. *Id.*

Some States even conducted formal studies of the possibility. One such study, authored by the Texas Health and Human Services Commission, discussed exactly the sorts of policy tradeoffs that States would have to make in order to opt out of Medicaid: "Opting out of Medicaid would require state policymakers to carefully prioritize services and take a practical approach to establishing financial and categorical eligibility standards. Individual responsibility and a pay for performance reimbursement system should be at the foundation of any new program." Texas Health and Human Services Commission and Texas Department of Insurance, *Impact on Texas if Medicaid Is Eliminated* at 32 (Dec. 2010).[9] Although the report ultimately suggested that "[r]edefining the relationship between the state and federal governments in the administration of the Medicaid program may be a preferable course of action" to refusing Medicaid funding altogether, *id.*, it seriously proposed a number of options that the State could take if it chose to drop out of Medicaid.

Of course, *amici* believe strongly that it would be a terrible policy decision for Texas—or any other State—to choose to drop out of the Medicaid program. This is likely the reason that many of the challengers have reversed course and now claim that it is impossible for them to refuse federal Medicaid funding. But of course the challengers' recognition that refusing Medicaid funding would be bad policy does not mean that doing so is impossible—just as the States' recognition in *Dole* that refusing federal funding would be a poor policy decision did not make the funding conditions on federal highway money unconstitutionally coercive.

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[8] *Available at* http://online.wsj.com/article/SB10001424052748704444304575628603406482936.html.

[9] *Available at* http://www.hhsc.state.tx.us/hb-497_122010.pdf.

III. ACCEPTING THE CHALLENGERS' ARGUMENTS WOULD UNSETTLE MEDICAID, UPEND MANY OTHER AREAS OF LAW, AND UNDERMINE CONGRESS'S ABILITY TO LEGISLATE.

As explained already, the ACA is by no means unique—a fact that strongly suggests that it does not present the sorts of extraordinary circumstances that would amount to coercion. For this reason, a ruling in favor of the challengers would have far-reaching effects beyond the ACA.

A. Reversal Would Call Prior Medicaid Expansions into Doubt.

Since its enactment in 1965, the Medicaid program has always invited States to accept significant federal funding in return for providing coverage for certain specified groups of people (although States are always free to cover additional groups). Since that time, Congress has enacted numerous expansions requiring the States to cover additional groups or to provide additional services to those groups already covered. For example:

> Congress embarked in 1984 on a series of Medicaid expansions that continued each year through the end of the decade. The expansions affected nearly the entire spectrum of Medicaid enrollees from infants, children, and pregnant women to low-income Medicare beneficiaries, and other aged and disabled enrollees. Initially, States were offered options to expand coverage of these groups, but ultimately most of the options were converted by subsequent legislation into mandates, most notably in the Medicare Catastrophic Coverage Act of 1988 (MCCA).

Medicaid Spending at 108.

If this Court invalidated the ACA as impermissibly coercive, many—if not all—of these prior expansions would be called into doubt. That is because past expansions have typically been achieved in the same way as the ACA's expansion—by amending 42 U.S.C. § 1396a(a) to require a state plan to cover additional patients or services. To give only a few examples, in 1984 Congress expanded Medicaid to cover children whose families met the income requirements for Aid to Families with Dependent Children but were not eligible for AFDC—coverage that had previously been optional. *See* American Academy of Pediatrics ("AAP") 11th Cir. Br. at 21 (Apr. 12, 2011); Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 § 2361. Similarly, in 1988 Congress mandated expansion of coverage for pregnant women and young children—coverage which had previously been optional. *See* AAP 11th Cir. Br. at 21. These past expansions thus offered the States the same choice the ACA offers here—provide the additional coverage or risk losing some or all Medicaid funding.

The challengers seek to avoid the fact that their argument would call past Medicaid expansions into question on the ground that less Medicaid funding was at issue. But the conditions imposed by past expansions remain conditions today and thus potentially condition all of a State's *current* Medicaid funding on compliance with their terms. If a State decided today not to comply with the conditions imposed by past expansions, it would risk losing all or part of its Medicaid grant.

Because past Medicaid expansions are indistinguishable from the ACA, a decision in favor of the challengers would threaten the Medicaid program as we know it, potentially leaving many of the citizens who depend on Medicaid without coverage. This point has not been lost on even the most vocal critics of the ACA, who have warned that striking the ACA as coercive could be disastrous. As Senator Charles Grassley (R-Ia.) explained recently, "A Supreme Court ruling in favor of the States in this case could not only jeopardize the mandated Medicaid expansion in the Affordable Care Act but could challenge the fundamental structure of Medicaid and have broader implications outside health care." 157 Cong. Rec. S8670, S8671 (daily ed. Dec. 15, 2011).

B. Reversal Would Call Many Other Programs Into Question Because Congress Routinely Places Conditions on the Receipt of Federal Funding.

A ruling in favor of the challengers would have effects far beyond Medicaid. It would call into question every federal law that imposes conditions on a significant amount of federal funding. These laws are ubiquitous across the political spectrum and range from cooperative federal-state programs to funding conditions imposed on all recipients of federal funding. They include programs like foster care, which provides billions of dollars in matching assistance to States, eligibility for which is subject to the State submitting a plan meeting numerous conditions indistinguishable from those imposed on the receipt of Medicaid funding. *See* 42 U.S.C. § 671. They also include numerous funding conditions that prevent discrimination by recipients of other sources of federal funding—including, for example, Title VI of the Civil Rights Act of 1964 (which prohibits racial discrimination "under any program or activity receiving Federal financial assistance," 42 U.S.C. § 2000d; *see also* 42 U.S.C. § 2000d-1) and Title IX of the Education Amendments of 1972 (which prohibits gender discrimination in any "education program or activity receiving Federal financial assistance." 20 U.S.C.A. § 1681(a); *see also* 20 U.S.C. § 1682).

A ruling in favor of the challengers also would not be limited to programs at the progressive end of the political spectrum; it would also threaten, for example, the Solomon Amendment, which requires educational institutions to provide military recruiters access equal to that provided to other recruiters or lose numerous categories of federal funding. *See* 10 U.S.C. § 983. This Court upheld the amendment only a few years ago, noting that "Congress's power to regulate military recruiting under the Solomon Amendment is arguably greater because universities are free to decline the federal funds." *Rumsfeld v. Forum for Academic & Inst. Rights, Inc.*, 547 U.S. 47, 59 (2006). And a ruling in favor of the challengers would undermine antiabortion legislation such as the No Taxpayer Funding for Abortion Act, H.R. 3, 112th Cong. (as passed by the House May 4, 2011), which would cut of federal funding for health-benefit plans—including state Medicaid plans—that cover abortion. *See* §§ *id.* 302, 305.

C. A Ruling For the Challengers Would Make It Difficult for Congress to Legislate.

The programs mentioned above are only a small subset of the numerous federal programs that condition substantial amounts of federal funding on the States' agreement to fulfill certain conditions—and for good reason. Without the ability to condition the receipt of funding on conditions, Congress would have very little control over how States use the funding it offers. Even the challengers appear to recognize that it would be absurd to construe the Spending Clause to require Congress to distribute money without imposing any conditions on the use of the funds.

Moreover, a ruling in favor of the challengers would greatly inhibit Congress's ability to create cooperative federal-state programs. At a minimum, such a ruling would prevent Congress from creating large cooperative programs, since any condition on participation in the program could be deemed coercive simply because of the amount of money at issue.

But such a ruling would likely dissuade Congress from designing smaller programs because it would be impossible to predict where the courts would draw the line between a large coercive program and a small non-coercive one. In addition, smaller programs would likely be affected because it is difficult to predict whether a small federal-state partnership might grow. Medicaid provides a good example: it began small but blossomed. Complicating matters further, Congress often does not have complete control over how large a program grows: Medicaid has grown in large part because the States have chosen to cover optional populations and services.

Ironically, then, a ruling in favor of the challengers would likely have a negative effect on our federalism. Because such a ruling would leave Congress with little control over how the States use federal grant money, Congress would be much less likely to make grants to the States at all, avoiding federal-state cooperative programs like Medicaid in favor of direct federal programs like Medicare. That result would lessen, not increase, state autonomy.

Congress could have chosen to federalize the Medicaid program, eliminating the States' role altogether. Perhaps some of the challengers would have preferred that option, but that would have left States with much less say over the design and implementation of the Medicaid program. Instead, Congress has chosen to work cooperatively with

States that volunteer to participate in the program, allowing States a great deal of autonomy to decide how much to reimburse providers and which optional populations to cover, among other things. But if this Court were to force Congress's hand, Congress could eliminate state participation in Medicaid altogether—leaving both the States and Congress worse off.

CONCLUSION

The Eleventh Circuit's judgment upholding the ACA's Medicaid expansion provision should be affirmed.

Respectfully submitted,

CHRISTOPHER J. WRIGHT
Counsel of Record
TIMOTHY J. SIMEONE
MARK D. DAVIS
WILTSHIRE & GRANNIS LLP
1200 18th Street N.W.,
Suite 1200
Washington, D.C. 20036
cwright@wiltshiregrannis.com
(202) 730-1300

PROFESSOR WALTER DELLINGER
1701 18th Street N.W.
Washington, D.C. 20009
(202) 383-5319

FEBRUARY 17, 2012

AMICUS CURIAE BRIEF

No. 11-400

In The
Supreme Court of the United States

Florida, *et al.*,

Petitioners,

v.

Department of Health
and Human Services, *et al.*,

Respondents

**On Writ of Certiorari to the
United States Court of Appeals
For the Eleventh Circuit**

BRIEF AMICI CURIAE OF DAVID R. RIEMER AND COMMUNITY ADVOCATES IN SUPPORT OF RESPONDENTS ON THE MEDICAID QUESTION

DAVID R. RIEMER
Senior Fellow
Community Advocates
Public Policy Institute
728 N. James Lovell St.
Milwaukee, WI 53233
(414) 270-2943
DRiemerMil@yahoo.com

DEAN A. STRANG *
Hurley, Burish &
Stanton, S.C.
33 E. Main St., Suite 400
Madison, WI 53703
(608) 257-0945
dstrang@hbslawfirm.com
* *Counsel of Record*

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INTEREST OF THE AMICI CURIAE

David R. Riemer and Community Advocates join in this brief in support of the respondents in No. 11-400 (Florida, *et al.* v. Department of Health and Human Services, *et al.*) with respect to the Medicaid question.[1]

Community Advocates (CA), founded in 1976, provides basic needs and advocacy services each year to tens of thousands of low-income, at-risk individuals and families in the Milwaukee area. The organization's services include health insurance advocacy. Every year, CA helps impoverished and uninsured Milwaukeeans to enroll in Wisconsin's Medicaid program and assists those ineligible for the program to find alternative ways of obtaining medical care.

David Riemer, Senior Fellow at the Community Advocates Public Policy Institute, is a health policy expert who has worked for over 35 years to create state and federal policies that expand health care coverage to low-income workers and control health care costs.[2]

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[1] No counsel for any party authored this brief in whole or in part. Neither counsel for any party, nor any party, made a monetary contribution intended to fund the preparation or submission of this brief.

In the 1970s, Riemer drafted Wisconsin's first Medicaid rule during the Administration of former Wisconsin Governor Patrick Lucey. He also worked on drug regulation and mental health policy reform for the U.S. Senate Subcommittee on Health and Scientific Research, chaired by the late Senator Edward Kennedy. Returning to Wisconsin in the 1980s, he helped to draft legislation that converted the state employee health plan into a large and long-lasting health insurance exchange.

While serving in the 1990s as budget director and administration director for Milwaukee Mayor John Norquist, Riemer teamed up with the Administration of former Wisconsin Governor Tommy Thompson to design the state's BadgerCare program. BadgerCare weaves together the portion of Medicaid that serves the poorest uninsured children and custodial parents with the State Children's Health Insurance Program (SCHIP) to greatly expand coverage for low-income families.

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[2] *See generally* http://ca-ppi.org (providing additional information on David Riemer and the Community Advocates Public Policy Institute).

In 2003, as State Budget Director for former Wisconsin Governor Jim Doyle, Riemer was responsible for preparing a biennial budget whose second largest program was a $4 billion Medicaid program.[3] The budget also further improved the state employee health plan's exchange mechanism.[4] From 2004 through 2007, as head of the Wisconsin Health Project, he coordinated the development of bi-partisan legislation to create a comprehensive state health insurance plan, which was folded into a bill passed by the Wisconsin State Senate.

In 2008, Riemer joined CA to lead its Public Policy Institute (PPI), and is now a Senior Fellow. Drawing on CA's experience in directly assisting poor people, and seeking to create for the poor and non-poor alike a rational system of comprehensive and affordable health insurance, Riemer and CA have worked to bring about policy changes at the state and national level. Their goal has been to persuade policy-makers to enact laws that expand health insurance coverage to the low-income uninsured population, control health insurance costs, and improve the quality of health care. Much of Riemer's and CA's work has focused on the ACA.

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[3] Division of Executive Budget and Fin., Dep't. of Admin., St. of Wis., *Budget in Brief*, 57 (2003) (see chart 11).

[4] *Id.* at 42-43.

Specifically, Riemer and CA have played a major role in Wisconsin, and a significant role nationally, in advocating for the expansion of BadgerCare coverage to low-income non-custodial parents (both in advance of and pursuant to the ACA's extension of Medicaid to this group) and for the creation of health insurance exchanges that utilize market forces—choice, competition, and incentives—to induce private insurance companies to hold down health insurance costs and improve the quality of health care.[5]

Advancing these positions on the uninsured and exchanges, Riemer served in 2010 and 2011 on the

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[5] See, *e.g.*, David R. Riemer and Alain Enthoven, *The Only Public Health Plan We Need*, New York Times (June 24, 2009), http://www.nytimes.com/2009/06/25/opinion/25enthoven.html; David R. Riemer, *Prescription for a Health Insurance Compromise: Forget the Public Option and Co-ops, Rewire the Exchange*, Committee for Economic Development (Sept. 24, 2009), http://www.ced.org/commentary/65-commentary/378-prescription-for-a-health-insurance-compromise-forget-the-public-option-and-co-ops-rewire—the-exchange.

Wisconsin Legislative Council Special Committee on Health Care Reform Implementation, as well as on the National Association of Social Insurance (NASI) Study Panel on Health Insurance Exchanges. In 2011, CA launched the Project for Health Insurance Exchange Education (PHIXE) to provide technical support to state policy-makers to design exchanges that are effective in controlling costs.

The low-income, uninsured individuals and families that CA serves, and on whose behalf Riemer and CA work, will benefit greatly if the ACA's Medicaid provision in dispute in this case is upheld.

If the Medicaid provision is found to be constitutional, health insurance will be extended to thousands of CA's clients who are now uninsured. Independent experts estimate that 340,000 uninsured individuals across Wisconsin will obtain health insurance due to a combination of the ACA's minimum coverage provision, expanded Medicaid eligibility for those below 133% of the Federal Poverty Level (FPL), and federal tax credits aimed at inducing low-to-moderate income individuals to obtain health insurance.[6]

On the other hand, eliminating the law's Medicaid expansion will mean that a large portion of the low-income uninsured clients that CA serves, along with hundreds of thousands of Wisconsin residents and millions of Americans, will remain uninsured.

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[6] In 2016, implementation of the ACA in Wisconsin is estimated to reduce the number of uninsured from 520,000 to 180,000. This expansion in insurance coverage is attributable in part to the ACA's extension of Medicaid to currently uninsured individuals below 133% of FPL, in part to the operation of the minimum coverage provision's incentive to those between 133% and 400% of FPL to obtain coverage, and in part to the law's federal tax credits for persons below 133%-400% of FPL who obtain coverage through a state health insurance exchange. Gorman Actuarial *et al.*, *The Impact of the ACA on Wisconsin's Health Insurance Market*, 7 tbl.2 (July 18, 2011), http://www.statereforum.org/system/files/gruber_study_august_2011.pdf (prepared for the Wisconsin Department of Heath Services).

SUMMARY OF THE ARGUMENT

The facts make clear that the provision of the Affordable Care Act (ACA) requiring states to expand Medicaid to persons below 133% of the Federal Poverty Level (FPL) does not impose "onerous conditions" on the states. Indeed, the law's expansion of Medicaid does not impose a burden on the states at all.

Several independent studies confirm that state cost increases directly attributable to the ACA's Medicaid expansion requirement are very modest, between 1.1% and 2.9%, because of federal matching rates of 90% or higher. When all of the law's Medicaid provisions are taken into account, state Medicaid spending actually *declines*. Finally, when the ACA's overall fiscal impact on states (including both Medicaid and non-Medicaid fiscal effects) is analyzed, the law reduces state spending to an even greater extent.

The ACA's Medicaid requirement and related ACA provisions do not so much impose fiscal pressure *on* the states as they relieve the states *from* fiscal pressure. There is no coercion to undertake a responsibility that adds net costs. There is no compulsion to require state taxpayers to pay more in order for the state to participate in an important federal program.

The ACA's Medicaid expansion requirement promotes the general welfare, is unambiguous, relates directly to the purpose of Medicaid, and does not require states to violate any constitutional prohibition. The law also does not impose "onerous conditions" on the states. Because the law meets all constitutional tests for when Congress may add a new requirement to a state-run program that is paid for largely with federal funds, the ACA's Medicaid expansion requirement is constitutional.

ARGUMENT

I. THE MEDICAID EXPANSION REQUIRED BY THE AFFORDABLE CARE ACT (ACA) DOES NOT IMPOSE "ONEROUS CONDITIONS" ON THE STATES.

A. New State Medicaid Spending Is Very Low Because of Large Federal Subsidies.

The state petitioners in No. 11-400 claim that the ACA's Medicaid expansion requirement will coerce the states into accepting "onerous conditions" that greatly increase state Medicaid spending as the *quid pro quo* for receiving matching federal Medicaid funding.

In fact, the ACA's major new Medicaid expansion requirement—that states must enroll uninsured individuals whose income falls below 133% of the Federal Poverty Level (FPL)[7]—will impose a very low burden on the states.[8, 9]

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[7] **Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271-79 (2010) (as amended) (citing the Patient Protection and Affordable Care Act since the law has not yet been fully codified in the United States Code). The ACA, in requiring that individuals below 133% of FPL are eligible for Medicaid, also requires that the first 5% of income**

In federal Fiscal Year (FY) 2009, state spending on Medicaid reached $123 billion, approximately 34% of the program's total cost of $366 billion.[10] During the 10-year period from FY 2000 through FY 2009, state general fund spending for Medicaid rose by an average of 5.4% *per year*.[11]

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must be disregarded. As a result, individuals below 138% of FPL are made eligible for Medicaid.

[8] The ACA also requires that states must provide individuals covered by Medicaid with a more standardized package of health insurance benefits. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302, 124 Stat. 119, 163-68 (2010).

[9] The ACA additionally requires state Medicaid programs to comply with "maintenance of effort" (MOE) standards regarding children and, under certain circumstances, adults. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(b)(1). States, however, have broad flexibility to counteract the fiscal impact of this requirement by declaring that they face a budget deficit and then removing adults above 133% of FPL from eligibility. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(b)(2). Because the MOE standards (a) by definition do not involve the *expansion* of Medicaid eligibility, and (b) give the states great latitude to avoid their fiscal impact, they are not addressed here as part of the discussion of whether the ACA policy of expanding Medicaid eligibility imposes "onerous conditions."

[10] Kaiser Family Found., *United States: Medicaid Spending*, http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=1 (last visited Dec. 29, 2011)(basing estimates on data from Centers for Medicare and Medicaid Services HCFA-64 reports (2011)).

[11] This 5.4% annual average increase in state Medicaid spending took place despite an $87 billion infusion of enhanced

By contrast, the additional state spending on Medicaid required by the ACA, as estimated by independent analysts using sophisticated modeling techniques, will range from 1.1% to 2.9% over a *five-year period.*

Separate recent studies by the Urban Institute[12] and the Lewin Group[13] address the issue

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federal Medicaid matching funds, provided to states as part of the American Recovery and Reinvestment Act (ARRA). This large infusion allowed states to actually reduce their spending on Medicaid for two years (state FY 2009 by 10.9% and FY 2010 by 7.1%), notwithstanding substantial increases in enrollment in Medicaid in FY 2009 (5.4%) and FY 2010 (8.5%). Without this massive one-time increase in federal matching dollars, the average increase in state Medicaid spending for the 10-year time period (state FY 2000 through 2009) would have been significantly greater than 5.4%. Reflecting the ending of the enhanced federal Medicaid match, states' adopted budgets for state FY 2011 showed an increase in state Medicaid spending of 13.1%. *See* Vernon K. Smith *et al.*, *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends—Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011*, Kaiser Commission on Medicaid and the Uninsured, 29 figs.22 & 24 (Sept. 2010), http://www.kff.org/medicaid/ upload/8105.pdf.

[12] The Urban Institute is an independent research organization, based in Washington, D.C., that carries out nonpartisan analyses of economic and social policy. Its President is Robert Reischauer, former head of the Congressional Budget Office (CBO). *See generally* http:// www.urban.org/about/.

of how much the ACA's Medicaid expansion requirements will actually cost the states. The Urban Institute, assuming a higher participation rate in Medicaid that would result in a higher overall level of Medicaid spending, estimates that the ACA requirement that Medicaid must cover individuals up to 133% of FPL will increase state Medicaid spending for the 2014-2019 period by 2.9%.[14] Assuming a lower participation that would produce a lower overall level of Medicaid spending, the Urban Institute estimates that the ACA's

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[13] The Lewin Group is a heathcare consulting firm, based in the Washington, D.C., area, that does policy research on a wide range of health issues. The Lewin Group has completed numerous independent, non-partisan evaluations of health insurance reform options, using a data-driven financial model. The Lewin Group was purchased in 2007 by Ingenix, a subsidiary of United Health Group, but maintains analytic and editorial independence from its parent company. *See generally* http://www.lewin.com/.

[14] John Holahan & Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, Kaiser Commission on Medicaid and the Uninsured, 46 tbl.12 (May 2010), http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

Medicaid expansion will increase state Medicaid spending for the 2014-2019 period by 1.4%.[15]

The Lewin Group estimate indicates an even lower cost impact on the states. Lewin calculates that the ACA's requirement that Medicaid must cover individuals up to 133% of FPL will cause state Medicaid spending for the same period—2014-2019—to rise by only 1.1%.[16]

There is no mystery why the ACA's Medicaid expansion requirements impose such a small cost burden on the states. The law accompanies its requirements for additional Medicaid coverage with an extremely generous federal pick-up of the overwhelming majority of the resulting costs. For every new dollar spent on persons made newly eligible for Medicaid, the ACA requires the federal government to pay *at least* 90% of the cost—100% for the first three years (2014 through 2016), 95%

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[15] *Id.* at 41 tbl.8.

[16] John Sheils *et al.*, *The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending*, 21-22 fig.7 (Dec. 9, 2010), http://www.lewin.com/content/publications/Lewin_Impact_of_Medicaid_Expansions_on_State_Spending.pdf.

for 2017, 94% for 2018, 93% for 2019, and 90% for 2020 and each year thereafter.[17]

Thus, if the only consideration were how much the ACA's expansion of Medicaid will cost the states, it should be clear that a cost increase that averages between 1.1% (Lewin) and 2.9% (Urban Institute, assuming a higher participation rate) cannot be deemed an "onerous condition."[18] Such very modest increases, however, tell only half the fiscal story.

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[17] Typically, state expenditures on Medicaid are "matched" by the federal government at a rate between 50% and 75%. Adjusted Federal Medical Assistance Percentage (FMAP) Rates for the Second and Third Quarters of Fiscal Year 2011 (FY11), 76 Fed. Reg. 32204-2 (June 3, 2011); for a historical, state-by-state summary of federal "matching" rates, *see* Kaiser Family Found., *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4 (last visited Dec. 29, 2011). Under the ACA, however, state spending for the newly eligible low-income individuals is "matched" by the federal government at much higher rates. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(2)(A), 124 Stat. 119, 271-72 (2010).

[18] Averages can sometimes be misleading, of course; but the state cost increases estimated by the Urban Institute and The Lewin Group are not. For example, the Urban Institute analysis—which showed, even assuming higher participation rates, that the average state Medicaid cost increase for the 2014-2019 period would be 2.9%—also estimated that only a single state would experience an increase above 7% (Arkansas at 7.9%); only a single state would see an increase between 6-7% (Mississippi at 6.4%); and only six states would face increases between 5-6%: Alabama (5.3%), Oklahoma (5.8%), Tennessee (5.4%), Texas (5.1%), Montana (5.7%), Nevada

B. New State Medicaid Spending Is Also Offset by Other ACA Provisions, Thus Enabling the States to Reduce Overall Medicaid Budgets.

The ACA includes several provisions that—when the law's impact on Medicaid is analyzed as a whole—will enable the states to *decrease* their total Medicaid spending. A separate study by the Lewin Group of the ACA's long-term costs found that, for the period 2010-2019, total state spending on Medicaid and SCHIP (State Children's Health Insurance Program) would *decline* by $39.3 billion.[19] For the longer period 2010-2029, Lewin estimated

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(5.2%). The Urban Institute analysis concluded that the vast majority of states would experience increases in the 1-4% range. Indeed, the analysis found that two states would experience reductions in state spending for Medicaid due to the new coverage requirement. *See* Holahan & Headen, *supra* note 14, at 46 tbl.12.

[19] The Lewin Grp., *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, 34 fig.23 (June 8, 2010), http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.

that states would see their Medicaid and SCHIP expenditures *fall* by $132.8 billion.[20]

Lewin identified two primary factors—the increase (already discussed) in the federal matching rates for newly eligible groups, and a 23% increase (up to 100%) in the federal matching rate for SCHIP enrollees—as the reasons why the ACA actually drives *down* states' net Medicaid expenditures.[21]

Another major area of Medicaid savings for states will be the states' decisions to eliminate Medicaid coverage (1) beginning in 2014, for adults living in families with income above 133% of FPL, and (2) beginning in 2019, for children living in families with incomes above 133% of FPL. The ACA does not require states to remove these groups from

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[20] *Id.*

[21] *Id.* at 11-12 ("The federal government will pay 100 percent of costs for newly eligible groups through 2016. Matching rates will phase down to 90 percent for newly eligible people in 2019 and thereafter. . . . In states that already cover the groups made newly eligible under the Act, the federal matching rates for these people will be phased up starting in 2014 at their current levels to 90 percent by 2019 and thereafter. The Act also increases the CHIP enhanced FMAP for states by 23 points, not to exceed a total matching rate of 100 percent.") *See also id.* at ii & 32.

Medicaid, but the law permits states to do so.[22] Most states will likely do so.

States will end Medicaid coverage for individuals in these two groups because doing so is a "win/win" proposition. Obviously, for states whose Medicaid programs now cover individuals above 133% of FPL, ending coverage for such adults—and later such children—will save the states a great deal of money. But dropping individuals from Medicaid when their incomes exceed 133% of FPL will not cause them to become uninsured. That is because the overwhelming majority of the individuals removed from the Medicaid rolls will be able to obtain, through the ACA's health insurance exchanges, large federal subsidies to pay for a "qualified health care plan" that provides Medicaid-like "essential health benefits."[23]

How much will states save by ending Medicaid coverage for individuals above 133% of FPL? A separate Urban Institute analysis estimates that by "eliminating...Medicaid coverage for adults over 133 percent of FPL, states can save between $21.3 billion and $28.2 billion."[24]

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[22] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001 (2010).

[23] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213, (2010).

Finally, the small increases in state Medicaid spending due to increased coverage for those below 133% of FPL will be offset *not only* by larger decreases in state Medicaid costs resulting from higher federal matching rates and the departure of former Medicaid enrollees, *but also* by very large net reductions in state and local costs *outside of* the Medicaid program.

According to the Lewin Group, state and local non-Medicaid "safety net" program costs will decline by $100.8 billion from 2010-2019, while state and local spending for their employees' health benefits programs will rise by $35.2 billion during the same period, for a net decrease in non-Medicaid state and local costs of $65.6 billion.[25] For the longer 2010-2029 period, Lewin estimates that state and local

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[24] Stan Dorn & Matthew Buettgens, Urban Institute, *Net Effects of the Affordable Care Act on State Budgets*, 1 (2010). http://www.urban.org/UploadedPDF/1001480-Affordable-Care-Act.pdf.

[25] *See* The Lewin Grp., *supra* note 19, at 34 fig.23.

"safety net" costs will fall by $391.8 billion, while employee costs will rise by $248.9 billion, a net non-Medicaid decrease of $142.9 billion.[26]

In short, when all of the fiscal impacts of the ACA are taken into account, the evidence indicates that no "onerous conditions" exist. Rather, the states will instead see a net *reduction* in their Medicaid spending. States will experience an even larger net *reduction* in total expenditures when costs and savings outside of Medicaid are factored in.

Both the Urban Institute and the Lewin Group have analyzed how much the ACA will save the states in total. For the 2014-2019 period, the Urban Institute's "worst-case scenario" calculates that states will see net budgetary savings of $40.6 billion, while under a "best-case scenario" state savings rise to $131.9 billion.[27] According to the Lewin Group, the ACA's net impact on state and local governments during the 2010-2019 period will produce net savings of $106.8 billion. For the longer

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[26] *Id.*

[27] *See* Stan Dorn & Matthew Buettgens, *supra* note 24.

2010-2029 period, Lewin estimates net savings of $237.6 billion.[28]

II. THE ACA'S MEDICAID EXPANSION SATISFIES EVERY CONSTITUTIONAL TEST DEFINED BY THE COURT FOR A NEW LAW THAT REQUIRES STATES TO MEET ADDITIONAL CONDITIONS TO CONTINUE RECEIVING FEDERAL FUNDS.

The Court has established four tests for determining whether Congress, in requiring the states to meet additional conditions to continue receiving federal funds, has acted within the limits of its spending power under Article I.[29] First, the exercise of spending power must be in pursuit of "the general welfare."[30] Second, the condition imposed on the states must be expressed unambiguously, so that the states can make an informed choice about whether to accept the condition.[31] Third, the condition must relate directly "to the federal interest" in the particular program.[32] Fourth, the condition may not be prohibited by another constitutional provision.[33]

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[28] *See* The Lewin Grp., *supra* note 19, at 34 fig.23.

[29] "The Congress shall have the power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States...." U.S. Constitution, Article I, § 8, cl. 1.

[30] *Helvering v. Davis*, 301 U.S. 619, 640-41 (1937).

The ACA's Medicaid expansion requirement meets all four spending power tests. First, expanding the Medicaid program so as to provide millions of uninsured Americans with health insurance, save lives, and improve health will clearly promote the nation's general welfare. Second, the condition that Congress has imposed, i.e., states must expand Medicaid to all persons up to 133% of FPL or lose federal Medicaid funding, is unambiguous. Third, the condition, which aims to increase the number of low-income individuals who are covered by Medicaid, relates directly to Medicaid's underlying purpose of providing low-income Americans with health insurance. Fourth, the condition does not—at least on its surface—violate any constitutional prohibition.

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[31] *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 17 (1981).

[32] *Massachusetts v. U.S.*, 435 U.S. 44, 461 (1978) (plurality opinion).

[33] *Lawrence County v. Lead-Deadwood School District*, 469 U.S. 256, 269-70 (1985).

The essence of the petitioners' argument, of course, is that the ACA's Medicaid expansion requirement runs afoul of a proposed fifth test—an amalgam constructed out of the limits of Congress' spending power, the Tenth Amendment, and basic principles of federalism—that prohibits the imposition on the states of "onerous conditions" in order to receive federal funds.

The status of such a fifth test is unclear, and its contours are imprecise. The Court has warned that "in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'"[34] The Court has never converted this warning into an enforceable test, however, by articulating the circumstances under which impermissible "compulsion" arises out of permissible "pressure" due to the type or magnitude of the financial inducement Congress might offer.

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[34] *South Dakota v. Dole,* 483 U.S. 203, 211 (1987) (citing *Stewart Machine Co. v. Davis,* 301 U.S. 548, 590 (1937)).

Wherever that line between "compulsion" and "pressure" may lie, its location does not bear on this case. Here, the new Medicaid expansion requirement that the states must meet, as a condition to continue their receipt of federal Medicaid funds, does not even impose fiscal "pressure" on the states because the requirement imposes no real cost at all. The ACA's Medicaid expansion requirement comes nowhere close to subjecting the states to "onerous conditions." Rather, when placed in context, the law's Medicaid expansion respects the balance struck by the Constitution between the states and the federal government.

III. CONCLUSION: CONGRESS' POLICY OF EXPANDING MEDICAID TO COVER MORE LOW-INCOME PERSONS AND LOWER STATE COSTS IS CONSITUTIONAL.

There is no question that Congress may modify Medicaid. States play a vital role in running and financing the program. But Congress created Medicaid, sets most of the rules, and pays over 60% of the cost.

There should also be no doubt that Congress may alter Medicaid by requiring states to cover more low-income persons, if doing so has minimal fiscal consequences for the states.

The Medicaid question in this case is whether the ACA's expansion of Medicaid eligibility in all states to 133% of FPL imposes such crushing costs on state governments that, even though states may respond by withdrawing from Medicaid, the new Medicaid expansion runs afoul of the balance struck between state and federal power under the Constitution.

The evidence—the actual data we have about the true cost of the ACA's expansion of Medicaid—makes clear that the ACA's Medicaid expansion does not impose "onerous conditions" on the states, but is constitutionally valid. Follow the money to understand why.

From 2000 through 2009, the states as a group added an average of 5% in spending every year to the amount they spend on Medicaid. By contrast, the future increase in state Medicaid spending directly attributable to the ACA's expansion requirement will only add between 1.1%

and 2.9% over an entire five-year period. The law's Medicaid expansion has such a modest impact because the federal government will pay between 90% and 100% of the cost of newly eligible groups.

The true fiscal impact on states, however, requires looking at the law's full set of federal Medicaid reimbursement policies.

The ACA, in addition to mandating that the federal government pick up between 90% and 100% of the cost for *newly* eligible groups, also increases the federal reimbursement rate for *existing* Medicaid eligibles. Thus, according to the Lewin Group, overall Medicaid costs will decline by over $39 billion by 2019, and will decline by more than $132 billion by 2029.

The ACA will also save the states money outside of Medicaid. When the law's overall impact on the states is calculated, the Lewin Group estimates that net state and local spending will fall by over $106 billion through 2019 and over $237 billion through 2029.

In sum, the law's expansion of Medicaid, when placed in its full context, *saves* states money.

The ACA comes nowhere close to imposing "onerous conditions" on the states that add up to the impermissible "compulsion" that *Dole* forbids.

Rather, the law's Medicaid expansion fully respects the constitutional balance between the states and the federal government. It should be upheld.

Respectfully submitted,

DAVID R. RIEMER
Senior Fellow
Community Advocates
Public Policy Institute
728 N. James Lovell St.
Milwaukee, WI 53233
(414) 270-2943
DRiemerMil@yahoo.com

DEAN A. STRANG *
Hurley, Burish &
Stanton, S.C.
33 E. Main St., Suite 400
Madison, WI 53703
(608) 257-0945
dstrang@hbslawfirm.com
* *Counsel of Record*

AMICUS CURIAE BRIEF

No. 11-393 and No. 11-400

In The
Supreme Court of the United States

National Federation of Independent Business, *et al.*,
Petitioners,
v.
Kathleen Sebelius,
Secretary of Health and Human Services, *et al.*,
Respondents

State of Florida, *et al.*,
Petitioners,
v.
Department of Health and Human Services, *et al.*,
Respondents

On Writ of Certiorari to the
United States Court of Appeals
For the Eleventh Circuit

BRIEF AMICI CURIAE OF DAVID R. RIEMER AND COMMUNITY ADVOCATES IN SUPPORT OF THE COURT-APPOINTED AMICUS CURIAE ON THE SEVERABILITY QUESTION

DAVID R. RIEMER
Senior Fellow
Community Advocates
Public Policy Institute
728 N. James Lovell St.
Milwaukee, WI 53233
(414) 270-2943
DRiemerMil@yahoo.com

DEAN A. STRANG *
Hurley, Burish &
Stanton, S.C.
33 E. Main St., Suite 400
Madison, WI 53703
(608) 257-0945
dstrang@hbslawfirm.com
* *Counsel of Record*

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INTEREST OF THE AMICI CURIAE

David R. Riemer and Community Advocates join in this brief in support of the Court-appointed *amicus curiae* in No. 11-393 (National Federation of Independent Business, *et al.* v. Kathleen Sebelius, Secretary of Health and Human Services, *et al.*) and No. 11-400 (State of Florida, *et al.* v Department of Health and Human Services, *et al.*) with respect to the severability question.[1]

Community Advocates (CA), founded in 1976, provides basic needs and advocacy services each year to tens of thousands of low-income, at-risk individuals and families in the Milwaukee area. The organization's services include health insurance advocacy. Every year, CA helps impoverished and uninsured Milwaukeeans to enroll in Wisconsin's Medicaid program and assists those ineligible for the program to find alternative ways of obtaining medical care.

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[1] No counsel for any party authored this brief in whole or in part. Neither counsel for any party, nor any party, made a monetary contribution intended to fund the preparation or submission of this brief.

David Riemer, Senior Fellow at the Community Advocates Public Policy Institute, is a health policy expert who has worked for over 35 years to create state and federal policies that expand health care coverage to low-income workers and control health care costs.[2]

In the 1970s, Riemer drafted Wisconsin's first Medicaid rule during the Administration of former Wisconsin Governor Patrick Lucey. He also worked on drug regulation and mental health policy reform for the U.S. Senate Subcommittee on Health and Scientific Research, chaired by the late Senator Edward Kennedy. Returning to Wisconsin in the 1980s, he helped to draft legislation that converted the state employee health plan into a large and long-lasting health insurance exchange.

While serving in the 1990s as budget director and administration director for Milwaukee Mayor John Norquist, Riemer teamed up with the Administration of former Wisconsin Governor Tommy Thompson to design the state's BadgerCare program. BadgerCare weaves together the portion of Medicaid that serves the poorest uninsured children and custodial parents with the State Children's Health Insurance Program (SCHIP) to greatly expand coverage for low-income families.

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[2] *See generally* http://ca-ppi.org (providing additional information on David Riemer and the Community Advocates Public Policy Institute).

In 2003, as State Budget Director for former Wisconsin Governor Jim Doyle, Riemer worked to further improve the state employee health plan's exchange mechanism. From 2004 through 2007, as head of the Wisconsin Health Project, he coordinated the development of bi-partisan legislation to create a comprehensive state health insurance plan, which was folded into a bill passed by the Wisconsin State Senate.

In 2008, Riemer joined CA to lead its Public Policy Institute (PPI), and is now a Senior Fellow. Drawing on CA's experience in directly assisting poor people, and seeking to create for the poor and non-poor alike a rational system of comprehensive and affordable health insurance, Riemer and CA have worked to bring about policy changes at the state and national level. Their goal has been to persuade policy-makers to enact laws that expand health insurance coverage to the low-income uninsured population, control health insurance costs, and improve the quality of health care. Much of Riemer's and CA's work has focused on the ACA.

Specifically, Riemer and CA have played a major role in Wisconsin, and a significant role nationally, in advocating for (1) the expansion of BadgerCare coverage to low-income non-custodial parents (both in advance of and pursuant to the ACA's extension of Medicaid to this group), and (2) the adoption of federal and state policies for the insurance exchanges created by the ACA that will enable them to be effective in covering uninsured individuals between 133% and 400% of the Federal Poverty Level (FPL), assisting small employers to obtain affordable coverage for their employees, and holding down health insurance costs while improving health care quality.[3]

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[3] *See, e.g.*, David R. Riemer and Alain Enthoven, *The Only Public Health Plan We Need*, New York Times (June 24, 2009), http://www.nytimes.com/2009/06/25/opinion/25enthoven.html; David R. Riemer, *Prescription for a Health Insurance Compromise*, Committee for Economic Development (Sept. 24, 2009), http://www.ced.org/commentary/65-commentary/ 378-prescription-for-a-health-insurance-compromise-forget-the-public-option-and-co-ops-rewire—the-exchange.

Advancing these positions on the uninsured and exchanges, Riemer served in 2010 and 2011 on the Wisconsin Legislative Council Special Committee on Health Care Reform Implementation, as well as on the National Association of Social Insurance (NASI) Study Panel on Health Insurance Exchanges. In 2011, CA launched the Project for Health Insurance Exchange Education (PHIXE) to provide technical support to state policy-makers to design exchanges that are effective in controlling costs.

The low-income, uninsured individuals and families that CA serves, and on whose behalf Riemer and CA work, will benefit greatly if, should the Court strike down the ACA's minimum coverage provision, the Court upholds the rest of the law.

If the ACA (except for the minimum coverage provision) is found to be constitutional, thousands of CA's low-income clients who are now uninsured will gain health insurance coverage. Those whose incomes fall below 133% of FPL will be able to enroll in an expanded Medicaid program. Those above 133% of FPL will be able to take advantage of the ACA's generous sliding-scale tax credit and use the new health insurance exchange to purchase individual policies from competing private insurers.

Upholding the ACA as a whole also will benefit CA's low-income clients—as well as the small employers that many of them work for—by creating a health insurance exchange that offers individuals and small firms a much wider range of health insurance choices. Other ACA provisions that will particularly help CA's low-income clients, if the law as a whole is upheld, include eliminating pre-existing medical conditions to deny coverage; letting parents keep their older children on their health insurance policies; expanding the Medicare prescription drug benefit; and preserving a long list of programs and policies that aim to control health care costs.

In short, the ACA is about much more than the minimum coverage requirement. If the Court should stretch the invalidation of that provision to strike down the entire legislation, thousands of CA's low-income clients—along with tens of thousands of Wisconsinites, millions of Americans, and the nation's small employers—will be needlessly harmed.

SUMMARY OF THE ARGUMENT

If the Court strikes down the ACA's minimum coverage requirement, that provision can be excised and the balance of the ACA allowed to stand.

Ample and independent evidence supports the conclusion that, even in the absence of the minimum coverage provision, the ACA's major policy goals will be accomplished and the basic structure of the law will successfully function.

One of the ACA's key goals is to greatly reduce the number of uninsured Americans. Regardless of the fate of the minimum coverage provision, the ACA will move the nation a long way towards achieving this goal.

According to two separate independent studies, one prepared by the Congressional Budget Office and another recently released by the Lewin Group, the number of uninsured Americans will decline *even if the minimum coverage provision is struck down* by between 10 million and 23 million. This large reduction in the uninsured population is due to a combination of: (1) the expansion of Medicaid to all low-income persons below 133% of the Federal Poverty Level (FPL), and (2) the provision of substantial subsidies to low-to-moderate income persons between 133% and 400% of FPL.

A second key goal of the ACA is to offer uninsured individuals above 133% of FPL and small employers a wide choice of health insurance options at an affordable range of premiums. Regardless of what happens to the minimum coverage provision, the ACA also will be able to achieve this goal.

The law's health insurance exchange mechanism will remain in place. The law's requirement that health insurance companies—whether they market through the exchange or not—must present individuals and small employers with health insurance plans that are easier to compare also will remain intact. And the law's prohibition against using "pre-existing medical conditions" to deny coverage or increase premiums, as well as its provision that allows parents to keep their children up to age 26 on their insurance plans, can continue to apply.

Finally, the third key goal of the ACA is to control costs. No matter what happens to the minimum coverage provision, the law's provisions that seek to achieve this—especially the creation of health insurance exchanges, and reforms of the Medicare payment system—will remain in place.

It would be disingenuous to maintain that striking down the minimum coverage provision will not hamper the goals and weaken the structure of the ACA. But to hamper is not to undermine. To weaken is not to destroy. Severing the minimum coverage provision will still allow the ACA to achieve the greater part of its goals and maintain its core structure. Under this Court's standards for severability, if the minimum coverage provision is struck down, the remainder of the ACA should stand.

ARGUMENT

I. IF THE COURT STRIKES DOWN THE MINIMUM COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT (ACA), THAT PROVISION CAN BE SEVERED WITHOUT UNDERMINING THE ACA'S BASIC GOALS AND STRUCTURE.

A. The Primary Policy Goal of the Minimum Coverage Requirement—Greatly Reducing the Number of Uninsured Americans—Will Be Accomplished Even If the Provision is Struck Down.

One of the ACA's basic goals—and the primary goal of the minimum coverage requirement—is to bring about a very large reduction in the number of uninsured Americans. Whatever the fate of minimum coverage provision, the ACA will continue to make major progress towards achieving that objective.

Striking down the minimum coverage provision will not diminish the law's expansion of Medicaid in every state to all persons below 133% of the Federal Poverty Level (FPL).[4] Nor will removing the minimum coverage provision disturb the sliding-scale subsidies offered to individuals between 133% and 400% of FPL if they opt to use their state's American Health Benefits Exchange to purchase an "essential health benefits package" from a "qualified health care plan."[5, 6] Together, the ACA's Medicaid expansion and tax subsidies will induce millions of currently uninsured Americans to obtain health insurance coverage.

Several studies by highly regarded, independent organizations confirm that, even if the

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[4] Patient Protection and Affordable Care Act Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271-79 (2010) (as amended) (citing the Patient Protection and Affordable Care Act since the Affordable Care Act has not yet been fully codifiedin the United States Code).

[5] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401.

[6] Striking down the ACA's penalty provisions would also not affect the law's that expand the scope of health insurance coverage by increasing the benefits that both uninsured and insured Americans receive, such as requiring both Medicaid as well as all plans sold in the individual and small group markets to provide at least "essential health benefits" and requiring Part D of federal Medicare program to expand level of insurance coverage for prescription drugs (by shrinking the so-called "donut hole"). Patient Protection and Affordable Care Act, § 1101.

ACA's minimum coverage requirement[7] were removed from the law, there would still be a very large reduction in the number of uninsured Americans.[8] The Congressional Budget Office (CBO), just a few weeks after the ACA was enacted, estimated that if the ACA were upheld in its entirely, it would shrink the number of nonelderly uninsured Americans from 49 million in 2010[9] to 23 million in 2019.[10] If the law's minimum coverage requirement were excised, however, the CBO estimated that the number of uninsured would decline from 49 million in 2010 to 39 million in 2019.[11] Thus, compared to a 26 million person decrease in the uninsured population, amounting to more than a 50% reduction, CBO estimated that the ACA *even without the minimum coverage requirement* will drive down the number of uninsured Americans by 10 million people, a substantial 20% reduction.[12]

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[7] The studies refer to the minimum coverage requirement as the "individual mandate."

[8] The studies differ in methodology. They also range in the magnitude of their estimates of the reduction in the size of the nation's uninsured population. What they all agree on is that—penalties or not—the Act will result in millions of uninsured Americans' gaining insurance coverage.

[9] Carmen DeNavas-Walt *et al.*, U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, 26 tbl.8 (Sept. 2011), http://www.census.gov/prod/2011pubs/p60-239 pdf.

[10] Congressional Budget Office, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, 2 (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_ Mandate_06_16.pdf.

[11] *Id.*

Another comprehensive analysis of this issue, published by the Lewin Group just a few days before the Court granted *certiorari* in these cases, concluded the ACA will dramatically reduce the number of uninsured, from a pre-ACA estimated level of 51.6 million, whether the minimum coverage requirement stays or goes.[13] The Lewin study concluded that, if the minimum coverage provision remains, the number of uninsured will drop to 20.7 million.[14] The Lewin study then calculated that, even if the minimum coverage provision were struck down, the ACA will still drive down the number of uninsured to 28.5 million.[15] In other words, compared to a 30.9 million person or 60% reduction in the uninsured population if the minimum coverage requirement stays in place, the ACA *even without the minimum coverage provision* will lower the number of uninsured Americans by 23.1 million, a huge 45% reduction.

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[12] Two other analyses have reached similar conclusions. Professor Jonathan Gruber of the Massachusetts Institute of Technology estimated that, while preserving the ACA's minimum coverage requirement would reduce the number of uninsured by 32 million or 65%, even in the absence of the minimum coverage provision the ACA would reduce the uninsured by approximately eight million or 16%. *See* Jonathan Gruber, *Health Care Reform Without the Individual Mandate,* Center for American Progress, 2 (Feb. 2011). http://www.americanprogress.org/issues/2011/02/gruber_mand date.html. An Urban Institute study estimated that preserving the ACA's minimum coverage requirement would reduce the number of uninsured by 24 million or 48%, while removing the minimum coverage provision would cause a reduction in the uninsured population of between 8 million and 10.5 million, or 16-21%. *See* Matthew Buettgens & Caitlin Carroll, Urban Institute, *Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care,* 5 (Jan. 2012). http://www.urban.org/publications/ 412480.html.

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[13] *See* DeNavas-Walt, *supra* note 9, that estimates the number of ***non-elderly*** uninsured in 2010 at 49.1 million, calculates the *total* number of uninsured Americans in 2010 to be 49.9 million. This is consistent with The Lewin Group's estimate that the total number of uninsured "before the act" is 51.6 million.

[14] John F. Sheils & Randall Haught, *Without the Individual Mandate, the Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted*, 30 Health Affairs, (Nov. 2011) at 6 (citing Exhibit 2), http://content.healthaffairs.org/content/early/2011/10/24/hlthaff.2011.0709.full.html. The analysis assumes that the ACA is fully implemented in 2011. The Lewin Group simulated the effect of the ACA using its Health Benefits Simulation Model. The model draws on "data from the [federal] Agency for Healthcare Research and Quality's Medical Expenditure's Panel Survey, data from the Kaiser Foundation's annual survey of employer health plans, and the most recent health spending and coverage date available from federal sources" to "simulate employers' decisions to offer coverage and to identify families that appear to be eligible for Medicaid and the premium subsidy programs based on their income." The model also simulates "changes in premiums and coverage resulting from reforms of the insurance markets" and "employers' decisions to either discontinue or start offering coverage, depending on the financial incentives they face under the Affordable Care Act." *See id.* at 3-4.

It is thus beyond dispute that millions—perhaps tens of millions—of uninsured Americans will gain coverage under the ACA even if the Court strikes down the law's minimum coverage requirement. The experts' analyses vary primarily on the magnitude.

But whichever analysis turns out to be closest to the mark, there should be no doubt that, even absent a minimum coverage requirement, several key ACA provisions will combine to make major progress towards achieving the law's fundamental coverage goal. The law's (1) expansion of Medicaid eligibility to everyone below 133% of FPL, (2) offer of sliding-scale tax credits to individuals between 133% and 400% of FPL, and (3) removal of current barriers such as the denial of insurance coverage to people with pre-existing medical conditions, ensure that result.

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[15] *Id.* at 6 (citing Exhibit 2).

B. The Other Major Goals of the ACA Will Also Be Achieved, and the Law's Structure Will Stand, Regardless of Whether the Minimum Coverage Requirement Is Upheld.

The fate of the ACA's minimum coverage requirement will have no effect on most of the other provisions of the law.

Whether the requirement is upheld or not, the law's expansion of Medicaid coverage will take place.

The deletion of the minimum coverage provision will also have only a limited impact on the ACA's new mechanism for providing individuals and small employers with a substantial expansion of affordable health insurance options—the individual exchange[16] and the small employer exchange.[17]

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[16] Formally known as the American Health Benefits Exchange. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(b), 124 Stat. 119, 173-74 (2010).

The Lewin Group analysis explains why the exchanges will still be able to provide large numbers of uninsured Americans with affordable coverage, despite worries about a so-called "death spiral":

> Many policy analysts fear that eliminating the individual health insurance mandate and penalty from the Affordable Care Act of 2010 would lead to a "premium spiral," in which healthy people would drop coverage, premiums would soar, and the number of people with coverage would plummet. However, there are other provisions of the law that would greatly mitigate this effect. For example, the subsidies provided in the law to help people purchase coverage through health insurance exchanges would restrain a premium spiral by absorbing much of the impact of premium increases.[18]

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[17] Formally known as the Small Employer Health Options Program (or SHOP Exchange). Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(b)(1)(B).

[18] *See* John F. Sheils & Randall Haught, *supra* note 14 at 1.

The Lewin study concludes: "Neither our simulations nor the available research demonstrates that the mandate is necessarily a 'linchpin' of the Affordable Care Act . . . ."[19]

Finally, whether the minimum coverage requirement survives or not, many other ACA provisions that aim to lower health care costs—including new initiatives designed to promote preventive and primary care, as well as important reforms of the Medicare payment system[20]—also will be able to go into effect.

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[19] *See* John F. Sheils & Randall Haught, *supra* note 14 at 7.

[20] *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4106, 124 Stat. 119, 559-60 (Medicaid coverage of evidence-based preventive services with no cost-sharing); Patient Protection and Affordable Care Act, § 2713 (prevention and wellness requirements for all new group and individual plans to provide first dollar coverage for certain preventive services); Patient Protection and Affordable Care Act, Title III; Patient Protection and Affordable Care Act, §§ 4103, 4104, 4105 (Medicare payment reforms, including the beginning of Medicare annual preventive and wellness visits and the waiver of all cost-sharing for preventive services); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022 (Accountable Care Organizations).

II. THE COURT'S RULINGS ON SEVERABILITY, AS APPLIED TO THE MINIMUM COVERAGE REQUIREMENT, LEAD TO ONLY ONE CONSTITUTIONAL OUTCOME — EVEN IF THE PROVISION IS STRUCK DOWN, THE REST OF THE ACA CAN BE UPHELD.

The three primary goals of the ACA are to (1) achieve a very large reduction in the number of uninsured Americans; (2) provide individuals and small employers with a substantial expansion of health insurance options; and (3) create new mechanisms for lowering health care costs.

Even if the Court strikes down the ACA provisions related to "minimum essential coverage," the law's remaining provisions and overall architecture will allow it to make enormous strides towards achieving these three fundamental purposes.

Independent experts have confirmed that, with or without the minimum coverage provision, the ACA will reduce the number of uninsured by millions—possibly tens of millions—of individuals.

The fate of the minimum coverage provision also will not alter the capacity of the law's new health insurance exchanges to provide individuals and small employers with a substantial increase in health insurance choices, unimpeded by current underwriting practices that deny coverage to people with pre-existing medical conditions.

Finally, this Court's decision about the minimum coverage does not impinge on a long list of other ACA programs and policies that aim to control health care costs.

Reasonable people will continue to disagree for years about whether the ACA's minimum coverage provision provision, as well as the law as a whole, represent good public policy. There simply is no reasonable basis, however, upon which the Court could conclude that striking down that single provision makes it impossible for the ACA to fulfill its major policy goals. Nor is there a basis upon which the Court could find that invalidating the ACA's minimum coverage requirement will fundamentally destroy the law's structure.

Thus, if the Court should invalidate the ACA's minimum coverage provision, the Court's long-established tests for severability[21] require that the provision should be surgically excised and the rest of the law can stand.

Respectfully submitted,

DAVID R. RIEMER
Senior Fellow
Community Advocates
Public Policy Institute
728 N. James Lovell St.
Milwaukee, WI 53233
(414) 270-2943
DRiemerMil@yahoo.com

DEAN A. STRANG *
Hurley, Burish &
Stanton, S.C.
33 E. Main St., Suite 400
Madison, WI 53703
(608) 257-0945
dstrang@hbslawfirm.com
* *Counsel of Record*

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[21] *See, e.g., Regan v. Time, Inc.,* 468 U.S. 641, 653 (1984) (presumption in favor of severability), *Ayotte v. Planned Parenthood,* 546 U.S. 320, 329 (2006) (normal rule is partial invalidation), and *Free Enterprise Fund v. Public Company Accounting Oversight Board,* 561 U.S. __ , 130 S. Ct. 3138, 3161-3162 (2010) (portions of law that are fully operative and capable of functioning independently must be sustained unless it is evident that legislature would not have enacted).

AMICUS
CURIAE
BRIEF

No. 11-400

In The
Supreme Court of the United States

◆

STATE OF FLORIDA, ET AL.,

Petitioners,

v.

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

◆

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

◆

BRIEF OF DAVID SATCHER, M.D., Ph.D.; ALLIANCE FOR CHILDREN AND FAMILIES; AMERICAN ASSOCIATION OF PEOPLE WITH DISABILITIES; AMERICAN ASSOCIATION OF UNIVERSITY WOMEN; CHILD WELFARE LEAGUE OF AMERICA; CHILDREN'S DEFENSE FUND; THE EDUCATION TRUST; LEAGUE OF WOMEN VOTERS; METHODIST HEALTHCARE MINISTRIES; NATIONAL ASSOCIATION OF GIRLS AND WOMEN IN SPORT; NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE; NATIONAL COUNCIL ON INDEPENDENT LIVING; NATIONAL FOSTER PARENT ASSOCIATION; NATIONAL ORGANIZATION OF STATE ASSOCIATIONS FOR CHILDREN; NORTH AMERICAN COUNCIL ON ADOPTABLE CHILDREN; PARALYZED VETERANS OF AMERICA; VET TO VET; VOLUNTEERS OF AMERICA; WOMEN'S SPORTS FOUNDATION; YWCA USA; AND 59 OTHER ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS (MEDICAID)

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Ira A. Burnim
Jennifer Mathis
Julia Graff
1101 15th St., NW, Suite 1212
Washington, DC 20005
(202) 467-5730

Samuel R. Bagenstos
Counsel of Record
625 S. State St.
Ann Arbor, MI 48104
(734) 647-7584
sbagen@gmail.com

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

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INTEREST OF THE *AMICI*

Amici are former Surgeon General David Satcher and a diverse group of child welfare, disability, education, health care, women's sports, veterans, and other organizations who are concerned that petitioners' argument against the Affordable Care Act's Medicaid expansion would unduly limit Congress's authority under the Spending Clause, U.S. Const., Art. I, § 8, cl. 1.[1] That argument, if accepted, would put at constitutional risk an array of federal statutes both in and out of the medical care context – statutes in which *amici* have an acute interest. *Amici* are listed and described in the Appendix to this brief.

◆

SUMMARY OF ARGUMENT

Petitioners argue that the Affordable Care Act's Medicaid expansion unconstitutionally coerces state choices. *South Dakota v. Dole*, 483 U.S. 203, 211 (1987). Petitioners' arguments prove far too much and are inconsistent with this Court's precedents and basic federalism principles.

A. The large amount of money the federal government offers the states under Medicaid cannot make the conditions attached to that program unconstitutionally coercive. To hold that it did would render the Medicaid Act – even before the Affordable Care Act's amendments – unconstitutional, and it would put at constitutional risk an array of federal education, child welfare, and other statutes enacted pursuant to the Spending Clause. But this Court's precedents make clear that the size of a federal grant does not provide a proper basis for invalidating a condition on that grant as coercive. For the financial inducement offered by Congress to become unconstitutionally coercive, that inducement must, at a minimum, deprive the state of something to which the state is otherwise entitled. See *College Sav. Bank v. Florida Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999); *New York v. United States*, 505 U.S. 144, 174-177 (1992). As this Court has explained, "Congress has no obligation to use its Spending Clause power to disburse funds to the States; such funds are gifts." *College Savings Bank*, 527 U.S. at 686-687. For a state, as for anyone else, the larger the gift that is offered, the more likely it is to be accepted. Medicaid, in particular, offers quite valuable consideration to states in exchange for participating – and this is especially so for the Medicaid expansion, which the federal government will subsidize at an unusually high rate. But that merely shows the value of the gift the federal government offers, not that it is coercive.

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[1] Counsel for the parties have filed with the Clerk blanket consents to the filing of *amicus* briefs in this matter. No counsel for a party authored this brief in whole or in part, and no person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief.

B. That "the Medicaid funds used to induce the States come from their own taxpayers" (Pet. 22; accord Pet. Br. 23, 27, 43, 53)[2] is of no constitutional moment. Petitioners' argument to the contrary, which would render coercive any conditional spending paid for by general federal taxes, is inconsistent with basic principles of federalism. As this Court's cases make clear, "the State and Federal Governments" have "concurrent authority over the people." *Printz v. United States*, 521 U.S. 898, 919-920 (1997). When the federal government collects taxes from people, it does not tax them as a state's residents. It taxes them "in their individual capacities" as "the people of America." *U.S. Term Limits, Inc. v. Thornton*, 514 U.S. 779, 839 (1995) (Kennedy, J., concurring) (internal quotation marks omitted). See also U.S. Const., Amend. XVI. In our federal system constructed according to these principles, the fact that the federal government taxes the same people as do the states does not deprive the states of anything to which they are entitled. Accordingly, it cannot be held to coerce the states into accepting conditional federal grants.

C. That Congress has imposed new, purely prospective conditions on the acceptance of Medicaid funds does not make the conditions coercive. Congress was under "no obligation" to give states funds to provide Medicaid in the first place, *College Savings*

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[2] In this brief, references to the petition for *certiorari*, brief on the merits, and *amicus* briefs are to filings in No. 11-400, which presents the Medicaid expansion question.

Bank, 527 U.S. at 686, and those funds do not become any less a "gift or gratuity," *id.* at 687, because Congress has provided them for a long period of time. Petitioners' argument that the states are so "dependen[t] on existing Medicaid funding" that they have no choice but to accept any conditions on continued receipt of that funding (Pet. Br. 41) is inconsistent with basic principles of federalism and governmental accountability. Moreover, it would render Medicaid unconstitutional even in the absence of the changes Congress effected in the Affordable Care Act, and it would put at constitutional risk other large and entrenched federal spending programs.

D. That Members of Congress may have expected all states to continue to participate in Medicaid does not bespeak coercion. All states participated in Medicaid before the Affordable Care Act expanded coverage, and, wholly independent of coercion, it would not be surprising that all would continue to participate in the program once the statute's nearly-fully-federally-funded coverage expansion went into effect. Members of Congress may often expect, correctly, that states will continue to participate in longstanding, popular cooperative spending programs that provide ample reimbursements. But no matter how well founded, those sorts of expectations neither constitute nor demonstrate coercion. See *Dole*, 483 U.S. at 211.

◆

ARGUMENT

In *Dole*, 483 U.S. at 207-208, this Court identified four "general restrictions" on the exercise of Congress's conditional-spending power under Article I, Section 8, clause 1 of the Constitution: that conditional spending be in pursuit of the general welfare; that any conditions on federal spending be unambiguous; that those conditions be sufficiently related to the federal purposes of the spending; and that the conditions not transgress any independent constitutional bar. None of those restrictions is at issue here. The *Dole* Court also explained that its decisions had "recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* at 211 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)). This case presents the question, which neither *Dole* nor *Steward Machine* answered, of what constitutes coercion in this context. See Pet. i. Petitioners' brief on the merits never provides a clear answer to that question, either. But it does suggest one by describing the paradigm case of coercion: "a thief produces a loaded gun and demands, 'your money or your life.'" Pet. Br. 46.

This case has virtually nothing to do with that paradigm case. Here, Congress has told each state, "Take billions of federal dollars on the terms we set, or don't take the money and simply provide for your residents however you see fit." If *that* choice – which, unlike "your money or your life," deprives a state of nothing to which it is otherwise entitled –

is unconstitutionally coercive, then a broad swath of other federal conditional spending statutes is at constitutional risk as well, notwithstanding petitioners' fervent protests to the contrary (Pet. Br. 53-59). These statutes include, at a minimum: the Medicaid Act itself (even before the amendments worked by the Affordable Care Act); Title I of the Elementary and Secondary Education Act and other statutes attached to federal education funding, such as the Boy Scouts of America Equal Access Act; the federal statutes providing funding for child welfare; and the jail and prison provisions of the Religious Land Use and Institutionalized Persons Act.

As *amici* show below, however, each of the pillars of petitioners' argument must fall. Neither the sheer size of the grant offered by the federal government to the states, nor the fact that general federal taxes are collected in part from state residents, nor Congress's decision to change the terms on which a state can continue to receive federal funds in the future – nor, even, the apparent assumption by Members of Congress that every state will choose to participate in the program – can render a cooperative spending program unconstitutionally coercive. That is clear from *Dole* and *Steward Machine* themselves, as well as this Court's discussions of coercion in its federalism jurisprudence, see *College Savings Bank*, 527 U.S. at 687; *New York*, 505 U.S. at 174-176, and its cases on conditional offers of federal money generally, see, *e.g.*, *Rust v. Sullivan*, 500 U.S. 173, 201-202 (1992); *Harris* *v. McRae*, 448 U.S. 297, 316-317 (1980). Petitioners' argument must therefore be rejected.

A. The Amount of Money the Federal Government Offers the States Cannot Make the Offer Coercive

Arguing that the 2010 amendments pass the point of coercion, petitioners rely heavily (Pet. Br. 30; see also Economists' Br. for Petrs. *passim*) on the large amount of money the federal government offers states to participate in the Medicaid program. Because they will have to leave the federal Medicaid program by 2014 if they do not wish to accept the new conditions on receipt of Medicaid funds imposed by Congress in the ACA, petitioners argue that those conditions are coercive. That argument misapprehends the doctrine of coercion this Court has applied in federalism and other cases.

1. Petitioners' argument necessarily extends not just to the Affordable Care Act's new conditions on the Medicaid program but to the Medicaid Act's conditions even as they existed before the ACA. The essence of Medicaid is that, in exchange for a very large amount of federal money,[3] states that choose to participate incur significant and detailed obligations to provide defined medical services to populations described by Congress. See *Frew ex rel. Frew v. Hawkins*, 540

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[3] As petitioners note (Pet. 6), the amount was "$251 billion in 2009 alone," which was "approximately 7% of federal spending."

U.S. 431, 433 (2004) ("State participation is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements."). If the large amount of money the federal government offers the states through the Medicaid program renders the new conditions coercive, then all of the other mandatory conditions that make up the Medicaid program – which are attached to the same large federal offers of money – must logically be unconstitutional as well. See also Nat'l Health Law Prog. Br. *passim*.

In addition, petitioners' argument would place at risk a variety of federal spending statutes outside of the Medicaid context. For example, the average state receives over half a billion dollars each year in grants under the two largest federal education grant programs alone,[4] and primary and secondary education makes up about a fifth of the average state's budget[5] – just less than does Medicaid. Congress has tied this massive federal aid to a number of conditions, including those imposed by the Boy Scouts of America Equal Access Act, 20 U.S.C. § 7905, under which a state puts at risk the funds it receives from the United States Department of Education if it does not permit the Boy Scouts "a fair opportunity to meet" in the public schools as required by the statute; Title I of the Elementary and Secondary Education Act, 20 U.S.C. § 6301 *et seq.*, as most recently amended by the No Child Left Behind Act of 2001, Pub. L. No. 107-110, 115 Stat. 1425 (2002), under which a state puts federal education funding at risk if it does not adopt standards and accountability measures;[6] and Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 *et seq.*, under which states that accept federal funds for education programs – whether or not those funds come from the Department of Education – must provide equal opportunities to women in those programs.

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[4] See U.S. Dep't of Educ., Guide to U.S. Dep't of Educ. Programs, Fiscal Year 2011, at 53, 245 (2011).

[5] See Nat'l Ass'n of State Budget Officers, Fiscal Year 2010 State Expenditure Report: Examining Fiscal 2009-2011 State Spending 3 (2011).

Other statutes, like the Religious Land Use and Institutionalized Persons Act, 42 U.S.C. § 2000cc-1(b)(1) (RLUIPA), attach conditions to the substantial federal funds that go to state jails and prisons.[7] And still more statutes attach conditions to other very large grants of federal funds, including those for child welfare,[8] vocational rehabilitation,[9] and child support enforcement.[10] Although this Court has held that aspects of some of these statutes, in their then-current versions, were not privately enforceable, see *Suter*, 503 U.S. at 350; *Blessing*, 520 U.S. at 332, or did not exact a waiver of state sovereign immunity, see *Sossamon v. Texas*, 131 S. Ct. 1651 (2011), it has never even suggested that they are unconstitutional. But cf. *Cutter v. Wilkinson*, 544 U.S. 709, 727 (2005) (Thomas, J., concurring) (stating that RLUIPA "may well exceed Congress' authority under either the Spending Clause or the Commerce Clause"). But under petitioners' argument, all of these statutes would be at risk of being held coercive, because they are attached to such large grants of federal funds.

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[6] See RAND Corp., Federal and State Roles and Capacity for Improving Schools 5 (2011) ("[S]tates could, in theory, opt out of Title I requirements. However, the federal government induces universal state participation through the sheer size of the financial resources attached to this policy.").

[7] See, *e.g.*, *Cutter v. Wilkinson*, 423 F.3d 579, 583 (6th Cir. 2005) (describing federal grants to the Ohio prison system under such programs as "the Violent Offender Incarceration and Truth in Sentencing Initiative Grants; the State Criminal Alien Assistance Program; grants intended for prisoner education, job training and treatment for drug addiction; and monthly payments under the Federal School Breakfast Program and Federal School Lunch Program").

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[8] See *Suter v. Artist M.*, 503 U.S. 347, 351 (1992) (Adoption Assistance and Child Welfare Act of 1980, 42 U.S.C. § 670 *et seq.*, "provides that States will be reimbursed for a percentage of foster care and adoption assistance payments when the State satisfies the requirements of the Act"); Casey Family Programs, Ensuring Safe, Nurturing, and Permanent Families for Children: The Need to Reauthorize and Expand Title IV-E Waivers 1 (May 2010), available at http://www.casey.org/resources/publications/pdf/NeedForWaivers.pdf ("The federal government spends more than $12 billion each year to support states' child welfare programs, representing almost half the funds that states expend on child welfare.").

[9] See 42 U.S.C. § 701 *et seq.* (creating federal grant program for vocational rehabilitation); 34 C.F.R. § 361.60(a) (federal government pays 78.7% of operating expenditures under state vocational rehabilitation programs); U.S. Dep't of Educ., *supra*, at 180 (federal government granted states more than $3 billion for vocational rehabilitation in Fiscal Year 2011).

[10] See *Blessing v. Freestone*, 520 U.S. 329, 333-334 (1997) (stating that the "Federal Government underwrites roughly two-thirds of the cost of the State's child support efforts").

2. There is no need for this Court to put these and other federal statutes at constitutional risk. That is because the size of a federal grant does not provide a proper basis under this Court's precedents for invalidating a condition on that grant as coercive. For the financial inducement offered by Congress to become "so coercive as to pass the point at which 'pressure turns into compulsion,'" *Dole*, 483 U.S. at 211 (quoting *Steward Mach.*, 301 U.S. at 590), that inducement must, at a minimum, deprive the state of something to which the state is otherwise entitled. Although neither *Dole* nor *Steward Machine* answered the question of what constitutes coercion in the Spending Clause context, this Court has addressed the question in other federalism cases – cases on which petitioners and their *amici* themselves rely (Pet. Br. 38, 52; Ind. Leg'ors Br. 20; Tex. Pub. Pol'y Found. Br. 10-11). Those cases show that coercion exists only when, as in petitioners' own "your money or your life" example (Pet. Br. 46), the federal government presents the state a choice between two options, both of which would deprive the state of something to which it is otherwise entitled.

In *College Savings Bank*, 527 U.S. at 687, for example, this Court concluded that "the point of coercion [was] automatically passed" when Congress put states to the choice of waiving constitutionally guaranteed immunity or being excluded "from otherwise lawful activity." The same analysis holds where conditional federal spending is involved. Thus, in *New York*, 505 U.S. at 174-177, this Court would have found the "take title" provision unconstitutionally coercive even if Congress had agreed to pay for the liabilities the state assumed when it took title to the radioactive waste at issue. Because the Tenth Amendment entitles states to refrain from *both* "regulating pursuant to Congress's direction" *and* taking title to and assuming liability for the radioactive waste privately generated within their borders, a state's decision to agree to the one of these options for which Congress had agreed to pay could not be understood as an uncoerced choice. See *id.* at 174-175. But where the options presented by Congress do not deprive states of anything to which they are otherwise entitled, and Congress makes the choice clear, this Court's precedent trusts the states themselves to "guard against excessive federal intrusion into state affairs and be vigilant in policing the boundaries of federal power." *Davis v. Monroe Cnty. Bd. of Educ.*, 526 U.S. 629, 655 (1999) (Kennedy, J., dissenting).

Petitioners attempt to liken this case to *New York*. They argue (Pet. Br. 52) that the Affordable Care Act's Medicaid expansion "effectively order[s] States either to regulate medical assistance for the needy according to Congress's dictates or to assume full responsibility for all medical assistance to the needy themselves." But there is a crucial difference between the cases. In *New York*, Congress offered states a choice between regulating according to its instructions or taking title to the waste at issue and assuming full *legal* responsibility for it. See *New York*, 505 U.S. at 153 (quoting "take title" section providing that the state "shall take title to the waste, be obligated to take possession of the waste, and shall be liable for all damages directly or indirectly incurred by such generator or owner as a consequence of the failure of the State to take possession"). Here, if a state does not wish to accept Medicaid funds and provide health care as Congress detailed, it need assume no new *legal* responsibility to provide medical care to its residents. Any responsibility it would assume would be a moral one – one that most people, to be sure, would find humane and appropriate, but one that, unlike in *New York*, is not dictated by Congress.

As this Court has explained, "Congress has no obligation to use its Spending Clause power to disburse funds to the States; such funds are gifts." *College Sav. Bank*, 527 U.S. at 686-687. When Congress offers funds to a state in exchange for complying with certain conditions, it generally *enhances* the choices available to that state. The state may decide to forgo the federal funding and thus lose nothing to which it was otherwise entitled. But the conditioned offer of funds gives the state a new, additional choice: it may decide to take on the conditions set by Congress in exchange for what it determines to be valuable consideration.

Petitioners indirectly suggest (Pet. Br. 32), and their *amici* affirmatively argue (Ctr. for Const. Juris. Br. 9; Tex. Pub. Pol'y Found. Br. 23), that this Court should adopt the understanding of coercion that appears in *United States v. Butler*, 297 U.S. 1 (1936). But *Butler*'s understanding of coercion – which was articulated in the context of coercion of *private* persons – is flatly inconsistent with the analysis *Dole* applied to the alleged coercion of *States*. Under *Butler*, the threatened "loss of benefits" where "[t]he amount offered is intended to be sufficient to exert pressure" on the benefits holder to agree to Congress's proposed course of action is itself "coercion by economic pressure." *Id.* at 70-71. *Dole*, by contrast, recognized that Congress may offer "financial inducement" to states to agree to its proposed course of action, and that such an inducement does not become unconstitutional "simply by reason of its success in achieving the congressional objective." *Dole*, 483 U.S. at 211. Even where the choices of individuals are involved – the context in which *Butler* discussed coercion – this Court has rejected *Butler*'s suggestion that, by their very nature, financial incentives designed to alter those choices constitute coercion. For example, the Court has consistently rejected claims that government decisions to fund childbirth but not abortion coerce women in the exercise of their constitutionally protected right to choose abortion. See, *e.g.*, *Rust*, 500 U.S. at 201-203; *McRae*, 448 U.S. at 315-317. The Court has so held even where it recognized that the purpose of this differential funding decision was to "encourage" women to choose childbirth. *Maher v. Roe*, 432 U.S. 464, 475-476 (1977). Because "[t]he Government has no constitutional duty to subsidize" even a constitutionally protected right, the Court held that that decision to subsidize childbirth but not abortion did not deprive anyone of anything to which they were otherwise entitled. *Rust*, 500 U.S. at 201.

Petitioners assert (Pet. Br. 15) that "[p]aying for Medicaid without any federal contribution would consume nearly two thirds of Florida's $32 billion in annual tax collection." But this simply highlights the value of the Medicaid program that Congress offers the states. Had Congress never offered it the chance to participate in Medicaid, Florida need not have provided medical benefits to its residents at all, or it might have decided instead to offer less generous benefits than does Medicaid. Had it chosen to provide the same benefits as Medicaid does, it would have had to raise revenues. But that does not make Congress's actions coercive. Cf. *Steward Mach.*, 301 U.S. at 588 (federal unemployment insurance program responded to the "failure by the States to contribute relief according to the measure of their capacity" and therefore to "contribute [their] fair share to the solution of a national problem").[11]

For a state, as for anyone else, the greater the consideration, the more likely it is that one will accept the offer. Where, as here, the federal government is offering billions of dollars, the offer may be especially attractive. But if that is so, that demonstrates only that the federal government is offering especially valuable consideration for choosing to undertake the conditions set by Congress. Here, for example, Congress chose to fund 100 percent of the cost of its coverage expansion initially, dropping no lower than 90 percent in later years. 42 U.S.C. § 1396d(y)(1).[12] It would be perverse to hold that, the more generous the federal offer, the more likely it will be held coercive. Congress's offer of billions of dollars in exchange for providing health care under the terms of the (pre- and post-ACA) Medicaid Act expands the choices available to the states. It does not deprive them of anything to which they are otherwise entitled. Accordingly, it is not coercive.

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[11] It is worth noting, in assessing "the measure of [Florida's] capacity" to raise revenue here, that Florida is one of nine states with no individual income tax.

B. That the Federal Tax Base Encompasses Residents of Each State Cannot Make an Offer of Federal Funds Coercive

Petitioners contend that the federal government's offer does deprive it of something to which it is entitled. This is because Medicaid, like most federal programs, is largely paid for by general federal taxes, and general federal taxes come, in large part, from people who reside in states. Petitioners argue that "[b]ecause the Medicaid funds used to induce the States come from their own taxpayers" (Pet. 22) the states have no choice but to participate in Medicaid if they want their indigent residents to obtain medical care. Indeed, petitioners refer throughout their merits brief to the fact that the general federal taxes that finance Medicaid (and most other federal programs) raise money "from residents of the States." Pet. Br. 27. See also *id.* at 23, 43, 53. Petitioners' argument, which would render coercive any conditional spending paid for by general federal taxes, is inconsistent with basic principles of federalism.

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[12] State governments were intimately involved in the legislative process that led to passage of the ACA. See John E. McDonough, Inside National Health Reform 150-151 (2011) (90-100 percent federal financial contribution to the ACA's Medicaid expansion resulted from pressure on Congress from individual governors). Though it is clear that petitioners would have liked to have negotiated a better deal, that does not make the offer they received and accepted coercive.

As a constitutional matter, states have no entitlement that "their own taxpayers" be shielded from any particular amount of federal taxation. Rather, the Constitution gives the federal and state governments concurrent power to tax the same people. As Justice Kennedy explained in *Cook v. Gralike*, 531 U.S. 510, 528 (2001) (Kennedy, J., concurring), "[t]he idea of federalism is that a National Legislature enacts laws which bind the people as individuals, not as citizens of a State." Our "Framers split the atom of sovereignty." *U.S. Term Limits*, 514 U.S. at 838 (Kennedy, J., concurring). The "great innovation" of their design "was that 'our citizens would have two political capacities, one state and one federal, each protected from incursion by the other' – 'a legal system unprecedented in form and design, establishing two orders of government, each with its own direct relationship, its own privity, its own set of mutual rights and obligations to the people who sustain it and are governed by it.'" *Printz*, 521 U.S. at 920 (quoting *U.S. Term Limits*, 514 U.S. at 838 (Kennedy, J., concurring)). They thus "designed a system in which the State and Federal Governments would exercise concurrent authority over the people." *Id.* at 919-920.

When the federal government collects taxes from people, it does not tax them as a state's residents. It taxes them "in their individual capacities" as "the people of America." See *U.S. Term Limits*, 514 U.S. at 839 (Kennedy, J., concurring) ("As James Madison explained, the House of Representatives 'derive[s] its powers from the people of America,' and 'the operation of the government on the people in their individual capacities' makes it 'a national government,' not merely a federal one.") (quoting The Federalist No. 39, at 244-245). This is especially so after the ratification of the Sixteenth Amendment, which eliminated the requirement that federal income tax be apportioned among the states. See U.S. Const., Amend. XVI.

In our federal system constructed according to these principles, the fact that the federal government taxes the same people as do the states does not deprive the states of anything to which they are entitled. Accordingly, it cannot be held to "coerce" the states into accepting conditional federal grants. Both the federal government and the states are free to tax the same people, without impinging on a constitutionally protected interest of the other, so long as they do not tax each other's *governments* in violation of the intergovernmental tax immunity doctrine. See

Jefferson Cnty. v. Acker, 527 U.S. 423, 436-439 (1999); *Davis v. Michigan Dep't of Treasury*, 489 U.S. 803, 811 (1989); *South Carolina v. Baker*, 485 U.S. 505, 523 & n.14 (1988).[13] That the federal government taxes the same people as do the states imposes no constitutionally cognizable harm. Put differently, the federal government need not offer a state *any* of the money it collects in taxes from people who reside in that state – and its spending programs need not help people in all states in the same measure. When the federal government nonetheless *does* offer states a substantial amount of the money it collects, it does not impose a *greater* restriction on state prerogatives.

A contrary rule would put at constitutional risk a wide range of federal statutes – a risk petitioners inadvertently highlight. In discussing this Court's decision in *Steward Machine*, *supra*, petitioners suggest that it is unconstitutional for Congress to provide money to states that opt into a cooperative federal-state program without setting up an alternative federal-only program to serve the residents of those states that opt out. See Pet. Br. 51 ("If Congress had passed such a statute, it would be analogous to the ACA, but it is impossible to believe that the *Steward Machine* Court would have blessed that statute as constitutional."). But statutes that provide federal funds only to participating states, without setting up alternative federal-only programs for the residents of nonparticipating states, are ubiquitous. Medicaid has *always* had this structure, so even without the amendments worked by the Affordable Care Act it would be in constitutional peril under petitioners' argument. The Elementary and Secondary Education Act similarly does not provide for federally-operated elementary and secondary schools in states that do not take Title I money; if a state does not participate in the program, other states will receive the money it would have. See 20 U.S.C. § 6311(a)(1) (Title I funds go only to states that submit a satisfactory plan to the Secretary of Education). The same is true of other federal-state education programs, such as the Individuals with Disabilities Education Act. See 20 U.S.C. § 1412(a). And the Adoption Assistance and Child Welfare Act similarly makes no provision for federally provided foster care and adoption assistance services in states that do not seek federal funds to provide the services themselves. See 42 U.S.C. § 671(a). These and many other statutes would likely be unconstitutional if petitioners' suggestion were the law.[14]

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[13] Declining to offer federal tax revenues to the states is thus a far cry, constitutionally speaking, from empowering individuals "to levy upon the treasuries of the States" for damages, which was the subject of this Court's decision in *Alden v. Maine*, 527 U.S. 706, 750 (1999). Cf. Indep. Inst. Br. 23.

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[14] More generally, federal spending virtually never benefits residents of each state in the exact proportion in which taxes come from residents of that state. See *America's Fiscal Union: The Red and the Black: Where Federal Taxes Are Raised and Spent*, The Economist Online (Aug. 1, 2011, 4:16 PM), http://www.economist.com/blogs/dailychart/2011/08/americas-fiscal-union (from 1990-2009, federal government collected over $956 billion

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Aside from its defects as a matter of constitutional doctrine, the claim that the Medicaid expansion coerces states by raising revenue "from their own taxpayers" fails as a matter of budget realities. Even when states and the federal government tax the same persons, they are not typically competing for the same finite body of revenue. For the past several decades, state and federal taxes have tended not to substitute for each other but instead to rise and fall at the same time. See, *e.g.*, C. Eugene Steuerle, Contemporary U.S. Tax Policy 34-36 (2d ed. 2008). A recent empirical study finds that increased federal taxes may shift *which* taxes the states assess, but that "[t]he overall burden of state taxation tends to be largely independent of federal tax burdens." Howard Chernick & Jennifer Tennant, *Federal-State Tax Interactions in the United States and Canada*, 40 Publius: The Journal of Federalism 508, 526 (2010). But whether state and federal taxes rise and fall together or are independent of one another, federal taxes cannot be said to crowd out those of the states. As this Court has recognized, the federal government, standing above the horizontal tax competition among states, can tap into a revenue base that states as a practical matter cannot. See *Helvering v. Davis*, 301 U.S. 619, 644 (1937) (recognizing that the federal government

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more in taxes than it spent in New York, while it spent more than $592 billion more than it collected in taxes in Virginia). In Florida itself, the federal government spent more than $298 billion more than it collected in taxes during the period of *The Economist*'s study. *Id.*

can raise revenues that states are "reluctant" to raise "for fear of placing themselves in a position of economic disadvantage as compared with neighbors or competitors").

C. That Congress Has Imposed New Prospective Conditions on Continued Acceptance of a Federal Grant Does Not Make the Grant Coercive

1. Petitioners argue (Pet. Br. 40) that the Medicaid expansion is coercive because it "plac[es] new conditions on continued receipt of all existing Medicaid funding." But the Spending Clause contains no rule of adverse possession. See *Bowen v. Public Agencies Opposed to Soc. Sec. Entrapment*, 477 U.S. 41 (1986). Congress was under "no obligation" to give states funds to create Medicaid in the first place, *College Sav. Bank*, 527 U.S. at 686, and those funds do not become any less a "gift or gratuity," *id.* at 687, because Congress has provided them for a long period of time. Although Congress may not act retrospectively to deprive states of a "vested right" such as "the fruits already reduced to possession of contracts lawfully made," *Public Agencies*, 477 U.S. at 55 (internal quotation marks omitted), Congress is free to act prospectively to stop providing the gift of funds to the states or to impose new terms on continued acceptance of that gift in the future.

By adopting new coverage requirements and providing that states can continue to receive federal

Medicaid funds after January 1, 2014, only if they adhere to those coverage requirements, Congress has not deprived states of anything to which they were entitled. Indeed, Congress has left them in a substantially better position than if it had ended Medicaid entirely, because states retain the option of continuing to receive federal funds so long as they agree to cover an additional population for which the federal government will reimburse at least 90 percent of the costs. But Congress surely has the right to end or fundamentally restructure a program of government largesse. A ruling that Congress was bound to continue Medicaid in the same form indefinitely would conflict with "the centuries-old concept that one legislature may not bind the legislative authority of its successors." *United States v. Winstar Corp.*, 518 U.S. 839, 872 (1996). That is why this Court has held "that, absent an 'unmistakable' provision to the contrary, 'contractual arrangements, including those to which a sovereign itself is a party, "remain subject to subsequent legislation" by the sovereign.'" *Id.* at 877 (quoting *Public Agencies*, 477 U.S. at 52 (quoting *Merrion v. Jicarilla Apache Tribe*, 455 U.S. 130, 147 (1982))).[15]

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[15] Indeed, petitioners' own *amici* argue that the Medicaid expansion – and, necessarily, Medicaid itself – is unconstitutional because it is an entitlement program that continues to spend after the end of the Congress that created it. See AAPS Br. 14-18. But that would be true only if petitioners themselves were correct that fundamental but prospective changes to an ongoing entitlement program are unconstitutionally coercive.

Although petitioners assert that they have created "a Medicaid infrastructure" based on the program rules as they previously existed (Pet. 22), states cannot reasonably rely on the expectation that a federal spending program will continue in a static form forever. Political shifts, changes in prevailing policy understandings, and budget disruptions are among the ever-foreseeable reasons that Congress may change the terms of such a program significantly. Indeed, from the moment they first agreed to participate in Medicaid, states have been on notice that Congress reserved to itself "[t]he right to alter, amend, or repeal any provision" of the statute pursuant to 42 U.S.C. § 1304 – the very same statute on which this Court relied in holding that Congress could prospectively change the terms under which it had previously agreed to provide Social Security to state employees. See *Public Agencies*, 477 U.S. at 51-52.[16]

Petitioners assert (Pet. Br. 40) that Congress's previous decision to extend them Medicaid funds has left them in a state of "dependency" that renders new conditions on the receipt of those funds coercive. But that notion of "dependency" proves far too much. If states are so "dependen[t] on existing Medicaid funding" (Pet. Br. 41) that they have no choice but to accept any conditions on the continued receipt of that funding, then even the conditions to which a state agreed when it originally entered the Medicaid program are now coercive. In other words, after a sufficient period of time, Medicaid itself became unconstitutionally coercive – and would have become unconstitutionally coercive even if Congress had left it entirely unchanged. The same would be true of any other conditional federal spending program that has become well entrenched. See, *e.g.*, RAND Corp., *supra*, at 6 n.3 (Elementary and Secondary Education Act Title I's "incentives are so large and ingrained that it is almost inconceivable for states to refuse them"). But that has never been the law.

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[16] Petitioners argue (Pet Br. 41-42) that this statutory provision cannot immunize a statutory change that is coercive. Petitioners miss the point. Petitioners' claim of coercion depends crucially on the argument that a midstream but prospective change to the rules governing continued receipt of Medicaid is necessarily coercive. But that argument must fail if the states had no entitlement to the continuation of the Medicaid program in its previous form in the first place. Title 42 U.S.C. § 1304 underscores that the states never had any such entitlement.

In any event, petitioners cannot show that they are "dependent" on Medicaid in any way that is constitutionally relevant. Petitioners say that certain of their *residents* have "come to depend" on Medicaid to receive medical services (Pet. Br. 41), and they refer obliquely to "the entrenched dependence of existing constituencies" (Pet. Br. 42). But all that seems to mean is that Medicaid provides valuable benefits to these residents and constituencies, benefits they will put pressure on state governments to retain. When a state's residents pressure their government to continue participating in a cooperative federal program, that is not coercion by the federal government – it is the very exercise of self-government and state sovereignty that this Court's federalism precedents contemplate. See *Printz*, 521 U.S. at 920 ("The Constitution thus contemplates that a State's government will represent and remain accountable to its own citizens."); *Board of Tr. of Univ. of Alabama v. Garrett*, 531 U.S. 356, 375 (2001) (Kennedy, J., concurring) ("States act as neutral entities, ready to take instruction and to enact laws when their citizens so demand."). Facilitating such acts of self-government is, in particular, the very purpose of this Court's Spending Clause notice jurisprudence. See, *e.g.*, *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (purpose of Spending Clause notice rule is to protect voluntary state choice).

2. One of petitioners' *amici*, Professor Blumstein, contends that it is not enough that Congress has always reserved the right to prospectively change the obligations imposed by Medicaid. He argues (Blumstein Br. 5) that the Medicaid expansion is unconstitutional because Congress did not make clear when it first enacted the program in 1965 that an expansion of coverage would occur in 2014. Professor Blumstein relies heavily (Blumstein Br. 12) on this Court's decision in *Bennett v. New Jersey*, 470 U.S. 632, 638 (1985), which held that a state's obligations under a conditional federal grant "generally should be determined by reference to the law in effect when the grants were made." But Professor Blumstein fatally misreads *Bennett v. New Jersey*. There, this Court held that a determination whether the United States could recover from New Jersey for a violation of conditions

attached to the Elementary and Secondary Education Act's Title I program must be based on the law in effect at the time the state applied for the Title I grant at issue – *viz.*, the years 1970 through 1972. See *id.* at 640. Congress had in 1978 amended the conditions states assumed when they accepted Title I grants. But the Court declined to apply those amendments retroactively to judge New Jersey's conduct under grants received before their enactment. See *id.* at 640-641. The Court explained that, at least as a general matter, "changes in the substantive standards governing federal grant programs do not alter obligations and liabilities arising under earlier grants." *Id.* at 641.

Bennett v. New Jersey thus draws a distinction between "changes in the substantive standards governing [a] federal grant program[ ]" – which are permissible so long as they do not apply to grants issued before the change – and changes in the obligations and liabilities attached to particular past grants – which generally are not. This is because the state must have notice of the obligations it assumes at the time it accepts a federal grant, see *Arlington Cent.*, 548 U.S. at 296, and it must have the chance to withdraw from a federal grant program before new grants are issued with different terms. Cf. *Guardians Ass'n v. Civil Serv. Comm'n*, 463 U.S. 582, 597 (1983) (opinion of White, J., announcing judgment of the Court) ("Remedies to enforce spending power statutes must respect the privilege of the recipient of federal funds to withdraw and terminate its receipt of federal money rather than assume the further obligations and duties that a court has declared are necessary for compliance."). But Congress is not forbidden from prospectively changing the terms on which the federal government will extend grants pursuant to an ongoing program. The Court made that point clear in *Bennett v. Kentucky Department of Education*, 470 U.S. 656 (1985), decided on the same day as *Bennett v. New Jersey*. In *Bennett v. Kentucky*, the Court held that Kentucky in 1974 violated a condition on Title I funding that Congress added in 1970, five years *after* Congress established the Title I program. *Id.* at 659-661, 673-674.

There is no doubt that the ACA's Medicaid requirement to expand Medicaid is purely prospective. It applies only to states that receive Medicaid funds after January 1, 2014, and it does not apply to Medicaid funds granted to states before that date. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). And no party disputes that Congress made a clear statement that continuing receipt of Medicaid funds beginning in 2014 requires compliance with the expanded eligibility provisions enacted in the ACA. That condition appears plainly on the face of the statute. See *id.* Cf. *Arlington Cent.*, 548 U.S. at 296-297 (Individuals with Disabilities Education Act did not provide clear statement that it authorized award of expert fees, where the statute made no express reference to expert fees).

Professor Blumstein nonetheless believes the notice Congress provided in the ACA is insufficient. Rather, he contends, Congress was required to "terminate traditional Medicaid" and "state clearly the conditions of state participation in New Medicaid" if it wanted to condition continued receipt of Medicaid funding on compliance with the new, expanded eligibility standards. Blumstein Br. 37. But aside from the suggestion that Congress should have renamed the program "New Medicaid," Professor Blumstein does not explain how that is any different than what Congress did. Congress stated plainly in 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) that no state can receive Medicaid funds after January 1, 2014, if it does not comply with the new terms of the program. Such a clear statement, this Court's cases make clear, is all that is necessary to impose a new condition on a federal grant. Congress is not required to change a statute's name, repeal and reenact it, or go through any other such empty formalities.

Professor Blumstein argues (Blumstein Br. 17, 28-29) that changing the terms of future grants after a state agrees to participate in a program is coercive because: states may have sunk costs in infrastructure necessary to participate in the program; they may have enacted legislation to implement their participation in the program, which legislation may as a matter of state law continue in effect even after the state stops receiving federal funds under that program; and a state's initial participation in a program may generate political constituencies that rely on it and support continued participation. But these phenomena – which are entirely contingent on the particular circumstances and state-law regimes of particular states – are just as likely to influence a state's decision to participate in an expressly renamed "New Medicaid" program after repeal and reenactment. And indeed, each is likely to influence a state's decision to continue participating in a conditional spending program that Congress has not changed at all. Professor Blumstein's novel argument must therefore be rejected.

D. That Members of Congress May Expect That All States Will Accept Federal Funding Does Not Render That Funding Coercive

Petitioners make much of the assertion that it was "inconceivable to the drafters of the ACA" that states would choose to leave the Medicaid program after the statute's coverage expansion. Pet. Br. 35. Accord *id.* at 38. They note that the structure of the Affordable Care Act suggests an expectation that many poor individuals will satisfy the statute's individual mandate through the Medicaid program. Pet. Br. 35-36. They assert that the absence of a "plan B" to enable otherwise Medicaid-eligible individuals to satisfy the individual mandate in states that opt out of Medicaid demonstrates that the statute is coercive. Pet. Br. 33. Although petitioners' arguments may show that Members of Congress *expected* that all states would continue to participate in Medicaid after the Affordable Care Act's coverage expansion, they do not come close to demonstrating coercion.

Wholly independent of any coercion, it should hardly be surprising that Members of Congress expected that all states would continue to participate in Medicaid after the Affordable Care Act's coverage expansion. After all, every state already participated in Medicaid, and the new statute will provide 100 percent federal reimbursement for its coverage expansion for the first three years, dropping to a steady-state reimbursement of 90 percent at the end of the decade. 42 U.S.C. § 1396d(y)(1). If the then-existing Medicaid program, with its much lower rate of federal reimbursement in most states, was sufficiently attractive to garner the participation of every state, Members of Congress would have had every reason to think that the program would remain attractive once the nearly-fully-federally-funded coverage expansion comes into effect. That is not coercion.

Precisely because the federal government must pay the states the consideration that they deem sufficient to obtain their assent to the conditions Congress sets, petitioners' fear of an "unlimited spending power" that "would be just as dangerous as a plenary regulatory authority" (Pet. Br. 29) is misplaced. The federal government's power to influence state behavior under the Spending Clause is inherently limited by Congress's ability and inclination to pay the price that states demand. Congress does not have limitless funds to offer the states to purchase their consent to new conditions. Indeed, Congress is now cutting the aid it provides the states under a variety of programs, and Medicaid itself is a prime target for future cuts and concessions to state demands for flexibility. See, *e.g.*, Sara Murray, *Nearly Half of U.S. Lives in Household Receiving Government Benefits*, Wall St. J. Real Time Econ. Blog (Jan. 17, 2012, 11:44 AM), http://blogs.wsj.com/economics/2012/01/17/nearly-half-of-u-s-lives-in-household-receiving-government-benefits/?KEYWORDS=health+overhaul ("[T]he rising federal deficit has brought government spending, and particularly benefits programs, under closer scrutiny. House Republicans, for example, have proposed block-granting Medicaid (the federal-state health care program for the poor) in order to cut costs."). These fiscal realities provide a built-in limit on Congress's power to use the Spending Clause to encourage states to take actions Congress could not require under its other enumerated powers. And, of course, *Dole* identified four limits on the spending power that are not at issue here. See *Dole*, 483 U.S. at 207-208.

As a predictive matter, Members of Congress may often expect that states will continue to participate in longstanding, popular cooperative spending programs that provide ample reimbursements. And those expectations may be well founded. See, *e.g.*, RAND Corp., *supra*, at 6 n.3 ("almost inconceivable" that states will stop participating in ESEA Title I program). But no matter how well founded, those sorts of expectations neither constitute nor demonstrate coercion. See *Dole*, 483 U.S. at 211 (conditional-spending program is not coercive "simply by reason of its success in achieving the congressional objective"). The crucial points, here, are that: (1) however much

Members of Congress may have expected states to remain in the Medicaid program, nothing in the Affordable Care Act deprives states that opt out of Medicaid of anything but continued federal funding; and (2) nothing in the Act penalizes needy individuals who are left unable to satisfy the individual mandate by their state's decision to opt out of Medicaid. Although Medicaid-eligible individuals are subject to the individual mandate, 26 U.S.C. § 5000A(d), individuals who cannot afford coverage or have a gross income below the tax-filing threshold are specifically exempted from paying a penalty for not satisfying the mandate, 26 U.S.C. § 5000A(e)(1), (2). See Sara Rosenbaum & Katherine Hayes, *The Misleading Arguments in the States' Medicaid Coercion Brief*, Health Affairs Blog (Jan. 19, 2012, 10:48 AM), http://healthaffairs.org/blog/2012/01/19/the-misleading-arguments-in-the-states-medicaid-coercion-brief/. Whatever were the expectations of Members of Congress about what states would choose to do, the Affordable Care Act does not coerce them into continuing to participate in Medicaid.

◆

CONCLUSION

The judgment of the court of appeals upholding the Affordable Care Act's Medicaid expansion should be affirmed.

Respectfully submitted,

IRA A. BURNIM
JENNIFER MATHIS
JULIA GRAFF
1101 15th St., NW, Suite 1212
Washington, DC 20005
(202) 467-5730

SAMUEL R. BAGENSTOS
Counsel of Record
625 S. State St.
Ann Arbor, MI 48104
(734) 647-7584
sbagen@gmail.com

Alphabetical List of *Amici*

1. *Advocates for Youth*
   Advocates for Youth is a national organization that partners with state and local organizations and provides technical assistance and training on adolescent reproductive and sexual health and rights. The organization champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health. Advocates for Youth is interested in the preservation and expansion of the Medicaid program, which is a critical step toward ensuring that low-income adolescents have access to adequate reproductive and sexual health services.

2. *AIDS United*
   The mission of AIDS United is to end the AIDS epidemic in the United States through national, regional and local policy/advocacy, strategic grant-making, and organizational capacity building. With partners throughout the country, AIDS United works to ensure that people living with and affected by HIV/AIDS have access to the prevention and care services they need and deserve. AIDS United has long advocated for increased access to Medicaid for people living with HIV who are currently ineligible for Medicaid benefits, particularly childless adults and/or those who do not meet the definition of disability.

3. *Alliance for Children and Families*
   The Alliance for Children and Families is a membership association that provides a variety of services to private nonprofit human service organizations throughout the United States and

Canada. Alliance members are organizations dedicated to serving children and families and/or that are focused on economic empowerment. Motivated by a vision of a healthy society and strong communities for all children and families, the Alliance works to strengthen the nonprofit human services sector and, through advocacy, assure the sector's continued independence. The Alliance for Children and Families supports the expansion of Medicaid eligibility in the context of overall reform that provides for the health and behavioral health needs of children and families. The Alliance values the health and well-being of all children, whose health is improved by early diagnosis and treatment.

4. *American Alliance for Health, Physical Education, Recreation and Dance*
   With 20,000 members, the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD) is the largest organization of professionals supporting and assisting professionals involved in physical education, recreation, fitness, sport and coaching, dance, health education and promotion, and all specialties related to achieving a healthy and active lifestyle. AAHPERD is deeply committed to preserving the federal government's ability to encourage the equitable participation of girls and young women in school sports teams through Title IX of the Education Amendments of 1972.

5. *American Association of People with Disabilities*
   The American Association of People with Disabilities (AAPD) is the Nation's largest cross-disability organization, advocating for equal

opportunity, economic power, independent living and political participation for persons with disabilities. The organization's more than 100,000 members come from all states and include persons with disabilities and their families, friends and supporters. The expansion of Medicaid in the Affordable Care Act will help many persons with disabilities get the support they need to live independent and healthy lives. Many other federal laws placing conditions on States' acceptance of federal funds, including laws furthering equal opportunities in education, are also of tremendous importance to persons with disabilities.

6. *American Association of University Women*
For 130 years, the American Association of University Women (AAUW), an organization of more than 100,000 members and donors, has been a catalyst for the advancement of women and their transformations of American society. In more than 1,000 communities across the country, AAUW members promote education and equity for all women and girls, lifelong learning, and positive societal change. Chief among the AAUW's priority issues is "increased access to quality, affordable healthcare" and the "vigorous protection of and full access to civil and constitutional rights." AAUW believes the Spending Clause is essential to enforcing and protecting Americans' civil and constitutional rights, as well as the general welfare.

7. *American Council for School Social Work*
The American Council for School Social Work (ACSSW) is a nationwide not-for-profit organization dedicated to promoting the practice of school

social work through research, education, and nonpartisan public advocacy. ACSSW serves as a national resource center on the practice of school social work for practitioners, schools, universities, legislators, and policy makers; educates the public about the services and practice of school social work; and monitors and advocates for national policies and legislation that support the practice of school social work and public education. ACSSW is interested in preserving the federal funding statutes that ensure the availability of social workers to assist students overcome barriers to learning, including Medicaid and the Individuals with Disabilities Education Act.

8. *American Federation of State, County & Municipal Employees*
AFSCME International is an unincorporated labor union with more than 1.6 million active and retired members working in the public sector, child care, and health care. AFSCME members include secretaries, librarians, cafeteria workers, caseworkers, lab technicians, researchers, nurses, bus drivers, heavy equipment operators, correctional officers, child care workers, and home care workers, among others. AFSCME has long advocated for expanding our nation's safety net for low-income Americans, and Medicaid's value is more important than ever, particularly in our current economic crisis. This issue affects the day to day lives of AFSCME's members and their families as both Medicaid beneficiaries and workers providing Medicaid services to beneficiaries. Moreover, AFSCME members care deeply about many other laws that function in whole or in part pursuant to the Spending Clause,

including the Supplemental Nutrition Assistance Program, the Federal-State Unemployment Insurance Program, the Occupational Safety and Health Act of 1970, and Titles IV-E and IV-D of the Social Security Act.

9. *American Mental Health Counselors Association*
The American Mental Health Counselors Association (AMHCA) seeks to enhance the profession of clinical mental health counseling through advocacy, education, licensing, and professional development. Among AMHCA members' major policy concerns is the adequacy of public funding to support the delivery of quality mental health services for all individuals in need. Medicaid is a particularly critical safety-net program for many persons with serious behavioral health needs. The Association is deeply committed to strengthening the Medicaid program nationally and in all states and territories.

10. *American Occupational Therapy Association*
The American Occupational Therapy Association (AOTA) is the national professional association established in 1917 to represent the interests and concerns of occupational therapy practitioners and students of occupational therapy and to improve the quality of occupational therapy services. Current AOTA membership is nearly 42,000, including occupational therapists, occupational therapy assistants, and occupational therapy students. Expanded access to Medicaid coverage is critical to permitting low-income Americans to access improved health, productivity, and quality of life through the therapeutic application of occupation.

11. *American Pain Foundation*
    The American Pain Foundation (APF) is an independent nonprofit organization serving 116 million Americans living with persistent pain through advocacy, information, and support. The Foundation's mission is to improve the quality of life of people with pain by raising public awareness, providing practical information, promoting research, and advocating to remove barriers and increase access to effective pain management. The Affordable Care Act is of critical importance to our constituency, as are other Spending Clause statutes such as the Medicaid Act.

12. *The Arc of the United States*
    The Arc of the United States (The Arc) promotes and protects the human rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes. The Arc consists of more than 700 state and local chapters across the United States, whose 140,000 members include people with intellectual and developmental disabilities, their families, and professionals in the field. The Arc and its members are vitally interested in the many critical services and supports funded through the Medicaid program, the Individuals with Disabilities Education Act (IDEA), the Elementary and Secondary Education Act (ESEA), No Child Left Behind Act, vocational rehabilitation programs, and other important federal

programs in which states are offered federal funds to implement programs with joint goals or as incentives to meet minimum standards of service provision.

13. *Association of Developmental Disabilities Providers*
The Association of Developmental Disabilities Providers (ADDP) is an organization that promotes the social, political and economic well-being of community organizations that support people with developmental disabilities and their families. ADDP represents 128 community providers who deliver residential, day and/or employment services throughout the Commonwealth of Massachusetts. ADDP represents the providers before the Department of Mental Retardation and the legislature and also provides technical training and in-service training to its members concerning best practice.

14. *Autistic Self Advocacy Network*
The Autistic Self Advocacy Network (ASAN) is a nationwide nonprofit organization run by and for individuals on the autism spectrum. ASAN promotes the interests of autistic children and adults through public policy advocacy, education, research, and cultural outreach activities. Many of ASAN's constituents rely on services provided through federal funding statutes such as Medicaid, the Education and Secondary Schools Act, and the Individuals with Disabilities Education Act.

15. *Behavior Business Partners*
Behavior Business Partners (BBP) is a consulting firm of experts with professional training in

applied behavioral psychology. BBP is concerned about the continued viability of federal spending programs like Medicaid and the many educational programs made possible with federal funding and important federal laws like the Elementary and Secondary Education Act, and the Individuals with Disabilities Education Act – laws that help America's youth become contributing members of the American workforce by developing into effective employees and employers.

16. *Brain Injury Association of America*
The Brain Injury Association of America (BIAA) is the country's oldest and largest nationwide brain injury advocacy organization. BIAA is committed to improving health care and services for people with brain injuries and for this reason, supports the expansion of Medicaid eligibility to reach many currently uninsured Americans living with brain injuries. In addition, the Association cares deeply about the ability of children with brain injuries to access needed supports and services through the Individuals with Disabilities Education Act.

17. *The Carter Center*
The Carter Center was founded in 1982 to advance human rights, peace, democracy, and access to health care. Rosalynn Carter leads the Center's efforts to improve U.S. public policies that can help prevent mental illnesses and increase equity in mental health care, holding an annual symposium with national leaders in mental health and other fields. The Carter Center supports the Patient Protection and Affordable Care Act's expansion of Medicaid eligibility as a

crucial mechanism for meeting the mental health care needs of millions of Americans living in poverty.

18. *Center for Children and Family Futures*
The Center for Children and Family Futures (CCFF) is a California-based, not-for-profit organization dedicated to improving the lives of children and families, particularly those affected by substance use and mental disorders. CCFF works to support States, Tribes, communities, and service providers in delivering comprehensive, evidence-based, integrated, and culturally relevant services to both children and parents affected by substance use and mental disorders, with the goals of family safety, well-being and recovery. The expansion of Medicaid coverage under the Affordable Care Act can provide significant opportunities for families, particularly families in the child welfare system, to access substance abuse and mental health services that had been previously unavailable.

19. *Center for Law and Education*
The Center for Law and Education, Inc. ("CLE") is a national nonprofit organization that works with parents, advocates, and educators to improve the quality of education for all students, and in particular, indigent students. CLE addresses systemic barriers that impede low-income students, who are disproportionately students of color and students with disabilities, from accessing a rigorous curriculum aligned to state standards through effective instruction from qualified teachers. CLE seeks to ensure that students who are entitled to services under Title I of

the Elementary and Secondary Education Act ("ESEA") and the Individuals with Disabilities Education Act ("IDEA") remain in school and receive an appropriate, quality education designed to prepare them for post-secondary education and employment. Both statutes were enacted, in whole or in part, pursuant to the Spending Clause, which remains critical to their implementation and enforcement.

20. *Child and Family Resources, Inc.*
Child & Family Resources, Inc. (CFR) is a private, community-based, nonprofit organization incorporated in 1970. CFR programs and services benefit 39,000 families and children throughout the State of Arizona each year. CFR's clients depend heavily on Medicaid and other federally funded programs provided through the State of Arizona and private agencies that contract with the State. CFR is particularly concerned with preserving Congress' ability to appropriate funds under the Individuals with Disabilities Education Act (IDEA); Title I of the Elementary and Secondary Education Act, most recently reauthorized in the No Child Left Behind Act; and the federal foster care and child support enforcement programs (Titles IV-E and IV-D of the Social Security Act).

21. *Child & Family Support Services*
Child & Family Support Services (CFSS) works with individuals and families with complex behavioral, developmental, or emotional needs throughout the state of Arizona. CFSS provides out-patient behavioral health services for children and families, including case management,

medication services, and specialized direct support services for children, young adults and families, many of which are financed by Medicaid and the IDEA. Many CFSS clients also benefit tremendously from federal foster care and child support enforcement programs provided for in Titles IV-E and IV-D of the Social Security Act.

22. *Children's Bureau, Inc.*
Children's Bureau, Inc. is a social service agency working on behalf of abused and neglected children and families in Indiana. Children's Bureau advocates for all children and families, providing a full array of community based prevention, family preservation and intervention services to more than 26,000 annually. The Bureau partners with the Department of Child Services and various other community organizations statewide. Children's Bureau cares deeply about preserving Congress' ability to appropriate funding to the States under Title IV-B and Title IV-E of the Social Security Act.

23. *Children's Defense Fund*
The Children's Defense Fund (CDF) is a nonprofit child advocacy organization that has worked relentlessly for more than 35 years to ensure a level playing field for all children. CDF champions policies and programs that lift children out of poverty; protect them from abuse and neglect; and ensure their access to health care, quality education and a moral and spiritual foundation. CDF has worked to ensure children truly benefit from the protections and conditions in Medicaid, the Title I Education Program for Disadvantaged Children, the Individuals with

Disabilities Education Act (formerly the Education for All Handicapped Children Act), the Adoption Assistance and Child Welfare Act, and the Juvenile Justice and Delinquency Prevention Act.

24. *Children's Home + Aid*
Children's Home + Aid serves 44,000 at-risk children and families throughout Illinois. The three core areas of program include early childhood, clinical/community services, and family-centered services/child welfare. A significant proportion of the children and families we serve are Medicaid-eligible, including nearly 1,000 foster children/wards of the state, many of whom have severe conditions requiring clinical intervention. To develop and protect these children's health, productivity and potential, Congress must retain the ability to fund Medicaid for these vulnerable populations.

25. *Child Welfare League of America*
The Child Welfare League of America (CWLA) is a coalition of hundreds of private and public agencies serving vulnerable children and families by advancing policies, best practices and collaborative strategies in support of every child growing up in a safe, loving, stable family. CWLA's focus is on children and youth who may have experienced abuse, neglect, family disruption, or a range of other factors that jeopardize their safety, permanence, or well-being. Vulnerable children and families need the support of safety net programs such as Medicaid and CHIP. CWLA is a strong champion of these programs and the expansion authorized under the Affordable Care Act, and we believe that these and other

important federal programs in which states are offered federal funds for these critical purposes must be preserved.

26. *Consortium for Children*
Consortium for Children (CFC) supports and collaborates with public child welfare agencies, families, the court system and other participants in the public child welfare system to provide better outcomes for children and youth in foster care. Consortium for Children has an interest in preserving the federal spending programs that ensure funding and accountability for state programs that affect child welfare, including Title IV of the Social Security Act, Medicaid, the McKinney-Vento Homeless Assistance Act, and the Individuals with Disabilities Education Act.

27. *David Satcher, M.D., Ph.D.*
David Satcher, M.D., Ph.D., served as the 16th Surgeon General of the United States, under Presidents Bill Clinton and George W. Bush. Dr. Satcher is a fellow of the American Academy of Family Physicians, the American College of Preventive Medicine, and the American College of Physicians, and is Board-certified in Preventive Medicine. He was a four-star admiral in the United States Public Health Service Commissioned Corps and served as the Assistant Secretary for Health. He founded and directs The Satcher Health Leadership Institute and Center of Excellence on Health Disparities at Morehouse School of Medicine. Dr. Satcher supports the expansion of Medicaid eligibility as a crucial step toward eliminating health disparities for low-income Americans and people of color.

28. *The Depression and Bipolar Support Alliance*
The Depression and Bipolar Support Alliance (DBSA) is the leading patient-directed national organization focusing on the most prevalent mental illnesses. DBSA disseminates up-to-date, scientifically based information to the public; supports research to promote the timely diagnosis and treatments; advocates for the equitable treatment and support of people living with mood disorders; and operates a grass-roots network of over 1,000 peer support groups across the country. DBSA is interested in preserving and expanding Medicaid, through which many of its constituents receive access to necessary treatment and support services.

29. *The Disability Rights Education & Defense Fund*
The Disability Rights Education & Defense Fund (DREDF), based in Berkeley, California, is a national non-profit law and policy center dedicated to advancing and protecting the civil rights of people with disabilities. Founded in 1979 by people with disabilities and parents of children with disabilities, DREDF remains board- and staff-led by members of the community it represents. Recognized for its expertise in the interpretation of federal disability civil rights laws, DREDF pursues its mission through education, advocacy and law reform efforts.

30. *The Education Trust*
The Education Trust is a nonprofit policy and advocacy organization that promotes high academic achievement for all students at all levels – pre-kindergarten through college. Education Trust's goal is to close the gaps in opportunity

and achievement that consign far too many young people – especially those from low-income families or who are black, Latino, or American Indian – to lives on the margins of the American mainstream. The Education Trust participates actively in national and state policy debates, bringing lessons learned from on-the-ground work and from unflinching data analyses to build the case for policies that will help all students and schools reach high levels of achievement. The Elementary and Secondary Education Act (ESEA) is core to the Education Trust's mission, as it ensures that states and local education agencies pay attention to the needs of their most vulnerable students and provide them with the same educational opportunities as their peers.

31. *EMQ Families First*
EMQ Families First is a nonprofit organization dedicated to helping families recover from trauma, abuse, addiction and poverty. It provides mental health treatment, foster care and social services to individuals across the state of California and advocates for improvements in the local, state and federal systems that serve children in need. EMQ Families First is interested in preserving and expanding federally funded programs including Medicaid, Title IV of the Social Security Act, the Individuals with Disabilities Education Act, and the McKinney-Vento Homeless Assistance Act.

32. *The Epilepsy Foundation of America®*
The Epilepsy Foundation of America® is the national voluntary agency dedicated solely to the welfare of the almost three million people with

epilepsy in the U.S. and their families. The Foundation works to ensure that people with seizures are able to participate in all life experiences; to improve how people with epilepsy are perceived, accepted and valued in society; and to promote research for a cure. In addition to programs conducted at the national level, epilepsy clients throughout the United States are served by more than 50 Epilepsy Foundation affiliates around the country. Federally funded services and programs such as Medicaid, the Education and Secondary Schools Act, and the Individuals with Disabilities Education Act are critically important to the epilepsy community.

33. *The Evan B. Donaldson Adoption Institute*
The Evan B. Donaldson Adoption Institute is a national, nonprofit organization devoted to improving adoption policy and practice. The Adoption Institute engages in research regarding adoption, trains and educates child welfare professionals, and advances public policies that support ethical, high-quality practices. The Institute's specific interest in this case arises from its commitment to maintaining the critical resources provided by the federal government, through Title IV-E of the Social Security Act, which successfully support the achievement of permanence through adoption for children with "special needs," and prevent them from languishing in foster care when the state terminates their parents' rights.

34. *Family Voices, Inc.*
Family Voices, Inc., is a national nonprofit organization of families whose children have

disabilities, chronic illnesses or other special health care needs. Its mission is to ensure that all such children receive family-centered care by providing families with tools to make informed decisions, advocating for improved public and private policies, building partnerships among professionals and families, and serving as a resource on health care and health care financing. The federal government's ability to establish standards for the Medicaid and State Children's Health Insurance Program (SCHIP) programs is of central interest to the members of the Family Voices network. Moreover, the Affordable Care Act's expansion of Medicaid will help young, low-income adults with special health care needs, who currently have "aged out" of Medicaid eligibility.

35. *FED ED*
FED•ED is a consortium of more than 110 Illinois school districts, educational organizations and corporate sponsors, representing the interests of suburban schools in our nation's capitol. The long-term funding interests of FED ED's member school districts lie in the full-funding of IDEA, Title I, and ESEA formula grants, which provide stable funds that can lead to sustainable change. FED ED's members have a great interest in preserving Congress's ability to appropriate monies to the States under these critical Spending Clause statutes.

36. *First Star*
First Star is a national nonprofit organization dedicated to improving the lives of America's abused and neglected children by strengthening

their rights, illuminating systemic failures and igniting necessary reforms. First Star is very concerned about preserving the federally established minimum standards required of states by statutes such as the Child Abuse Prevention and Treatment Reauthorization Act of 2010.

37. *Foster Family-based Treatment Association*
The Foster Family-based Treatment Association (FFTA) represents more than 400 member agencies, and is the country's leader in treatment foster care. FFTA provides Program Standards, technical assistance, professional development programs and other resources to help agencies achieve positive outcomes. FFTA's members provide treatment foster care services to more than 50,000 children and youth each year and a larger array of services to more than 600,000 children and youth throughout North America. FFTA also advocates for the federal funding and accompanying standards necessary to provide the intensive mental health and family-based services that our most vulnerable children and youth need to stabilize and thrive.

38. *The John Burton Foundation for Children Without Homes*
The John Burton Foundation for Children Without Homes is a nonprofit organization based in San Francisco, California dedicated to improving the quality of life for California's homeless children and developing policy solutions to prevent homelessness through research, advocacy, community organizing and coalition building. The Foundation strongly supports the expansion of Medicaid eligibility to millions of currently

uninsured, low-income children, many of whom are homeless or at risk of homelessness. In addition, the Foundation is heavily invested in maintaining Congress' ability to provide funds to the States for the education of homeless children through the McKinney-Vento Homeless Assistance Act.

39. *The League of Women Voters*
The League of Women Voters of the United States is a nonpartisan, community-based political organization that encourages the informed and active participation of citizens in government and influences public policy through education and advocacy. The League is organized in eight hundred communities, in every State, with more than 150,000 members and supporters nationwide. Founded in 1920, the League has long supported federal Spending Clause legislation that carries out the League's principles and positions, which include promoting social and economic justice and the health and safety of all Americans.

40. *Learning Disabilities Association of America*
The Learning Disabilities Association of America (LDA) is the largest nonprofit volunteer organization in the country advocating for individuals with learning disabilities, with more than 200 state and local affiliates in 42 states and Puerto Rico. The membership, composed of individuals with learning disabilities, family members and concerned professionals, advocates for the almost three million students of school age with learning disabilities and for adults affected with learning disabilities. LDA is deeply concerned about maintaining federal funding for public education, and

supports and services for children with disabilities, through the Individuals with Disabilities Education Act (IDEA); the Elementary and Secondary Education Act (ESEA), recently reauthorized in the No Child Left Behind Act; and the Adult Education and Family Literacy Act.

41. *Mental Health America*
Mental Health America (MHA) is the country's leading nonprofit dedicated to helping all people live mentally healthier lives. With more than 240 affiliates nationwide, MHA represents a growing movement of Americans who promote mental wellness for the health and well-being of the nation – everyday and in times of crisis. MHA fully supports the expansion of Medicaid in the Affordable Care Act, which will permit many currently uninsured Americans the ability to access the mental health care they need.

42. *Methodist Healthcare Ministries*
Methodist Healthcare Ministries (MHM) is a private, faith-based, not-for-profit organization dedicated to providing medical, dental and health-related human services to low-income families and the uninsured in South Texas. The mission of the organization is "Serving Humanity to Honor God" by improving the physical, mental and spiritual health of those least served in the Southwest Texas Conference area of The United Methodist Church. MHM is one-half owner of the Methodist Healthcare System – the largest healthcare system in South Texas. MHM supports the expansion of Medicaid eligibility as a crucial step toward ensuring that our nation can meet the health care needs of the least served.

43. *National Alliance to Advance Adolescent Health* The National Alliance to Advance Adolescent Health is a nonprofit organization that works to improve the lives of adolescents, especially those from poor families, by focusing greater attention and resources on their health needs and on innovative ways to address those needs. The National Alliance aims to increase adolescents' access to integrated physical, behavioral, and sexual health care and to expand holistic health promotion strategies for adolescents in their communities. The National Alliance recognizes the importance of the Medicaid program in ensuring that our nation's adolescents have access to comprehensive health care.

44. *National Association for Girls and Women in Sport* The National Association for Girls and Women in Sport (NAGWS) is an association of female athletes and professionals devoted to the development of equitable and quality sport opportunities for all girls and women through relevant research, advocacy, leadership development, educational strategies, and programming in a manner that promotes social justice and change. NAGWS is deeply committed to preserving the federal government's ability to encourage the equitable participation of girls and young women in school sports teams through Title IX of the Education Amendments of 1972.

45. *National Association of County Behavioral Health & Developmental Disabilities Directors*
The National Association of County Behavioral Health & Developmental Disabilities Directors (NACBHDD) advocates for county and local behavioral health and developmental disability authorities in Washington, DC. Through education, policy analysis, and advocacy, NACBHDD promotes national policies that recognize and support the critical role counties play in caring for people affected by mental illness, addiction, and developmental disabilities. NACBHDD is also an active partner in efforts to improve access to, funding for, and quality of behavioral health services, especially those that serve the most vulnerable in our communities. For this reason, NACBHDD fully supports the expansion of Medicaid eligibility in the Patient Protection and Affordable Care Act.

46. *National Association of People Living with AIDS*
The National Association of People Living with AIDS (NAPWA) is the first coalition of people living with HIV/AIDS in the world, as well as the oldest AIDS organization in the United States. NAPWA advocates for the lives and dignity of all people living with HIV/AIDS, especially the more than one million Americans who live with it today. Through legislative advocacy, public education, and capacity-building, NAPWA works to end the HIV/AIDS epidemic in America. The Affordable Care Act's expansion of Medicaid eligibility is a critical step toward ensuring that all persons living with HIV have access to HIV medical care, including HIV medications, and to help close the

gap in access based on individuals' State of residence.

47. *National Coalition for the Homeless*
The National Coalition for the Homeless works to bring about the systemic changes necessary to prevent and end homelessness and to protect the rights of people experiencing homelessness. Homeless people suffer from multiple health problems at a rate far higher than the general U.S. population, yet 55 percent have no medical insurance. The Coalition strongly supports the expansion of Medicaid eligibility to millions of currently uninsured, low-income Americans, many of whom are homeless or at risk of homelessness. In addition, the Coalition is heavily invested in maintaining Congress' ability to provide funds to the States through the McKinney-Vento Homeless Assistance Act.

48. *National Council for Community Behavioral Healthcare*
The National Council for Community Behavioral Healthcare represents 1,900 behavioral healthcare organizations that serve our nation's most vulnerable individuals – more than 6 million adults and children with mental illnesses. The National Council promotes public policies that improve and strengthen mental health and addictions treatment by promoting access to high-quality, cost-effective community-based treatment and supports. The National Council is interested in the preservation and expansion of Medicaid as a critical step toward ensuring that people with mental illness have access to adequate health care. In addition, the Council cares

deeply about the ability of children with emotional disturbance to access needed supports and services through the Individuals with Disabilities Education Act.

49. *National Council on Independent Living*
The National Council on Independent Living (NCIL) is America's oldest cross-disability, grassroots organization run by and for people with disabilities. Founded in 1982, NCIL represents more than 700 organizations and individuals from every state and territory, including Centers for Independent Living (CILs), Statewide Independent Living Councils (SILCs), individuals with disabilities, and other organizations that advocate for the rights of people with disabilities throughout the United States. NCIL is committed to preserving and expanding access to critical health care through Medicaid. NCIL is also concerned about the vitality of many spending clause statutes, including the Individuals with Disabilities Education Act (IDEA) and Title I of the Elementary and Secondary Education Act, most recently reauthorized in the No Child left Behind Act.

50. *National Council of Jewish Women*
The National Council of Jewish Women (NCJW) is a grassroots organization of 90,000 volunteers, advocates, and supporters who turn progressive ideals into action. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms. NCJW works for quality, comprehensive, confidential, nondiscriminatory health-care

coverage and services, including mental health care, that are affordable and accessible for all, and supports the expansion of Medicaid eligibility in the Patient Protection and Affordable Care Act.

51. *National Education Association*
The National Education Association (NEA) is a nationwide employee organization with more than 3 million members, the vast majority of whom are employed by public school districts, colleges, and universities. NEA supports the federal government's legitimate and proper role in ensuring equity and adequacy of educational opportunity for all, including by granting aid to the States in pursuit of national interests in public education under the Elementary and Secondary Education Act.

52. *National Federation of Families for Children's Mental Health*
The National Federation of Families for Children's Mental Health advocates for children and youth with emotional, behavioral and mental health challenges and their families. The Federation has more than 2,500 individual members and provides support to a nationwide network of more than 150 family-run or youth-guided organizations. The Federation believes it is crucial that Congress be able to set standards and guidelines as a part of the requirement for states' acceptance of federal funding for important federally funded programs, such as the Individuals with Disabilities Education Act (IDEA); Title I of the Elementary and Secondary Education Act, most recently reauthorized in the

No Child Left Behind Act; the federal foster care and child support enforcement programs (Titles IV-E and IV-D of the Social Security Act); and Medicaid.

53. *National Foster Parent Association*
The National Foster Parent Association (NFPA) is a nonprofit, volunteer organization established to provide leadership and guidance to its members and to advocate for public policies designed to improve our nation's foster care system. As the "national voice for foster parents," the NFPA leads the way for the more than 120,000 foster families in this great country caring for the estimated 480,000 children in foster care. The NFPA is deeply concerned about preserving the federal foster care and child support enforcement programs (Titles IV-E and IV-D of the Social Security Act).

54. *National Organization of State Associations for Children*
The National Organization of State Associations for Children (NOSAC) assists and supports more than 35 State associations that advocate for children, particularly those in foster care and related services. NOSAC supports the expansion of Medicaid eligibility, which is critical to the health and well-being of so many currently uninsured children and families. NOSAC is also deeply concerned about preserving Congress' ability to fund foster care and child support enforcement programs and to enforce important quality standards in services delivered through such programs, though Titles IV-E and IV-D of the Social Security Act.

55. *National Respite Coalition*

The National Respite Coalition (NRC), the policy division of the ARCH National Respite Network, is a national organization of more than 300 paid members, including individuals of all ages with disabilities and mental health conditions, their family caregivers, respite providers, community and faith-based agencies, state and national organizations. NRC works to secure quality, accessible, planned and crisis respite services for all families and caregivers in need of such services to strengthen and stabilize families, and enhance child and adult safety. The National Respite Coalition supports the Affordable Care Act's expansion of Medicaid eligibility, which will allow many more caregivers and recipients to receive much-needed respite and crisis care services.

56. *National Urban League*

The National Urban League is an historic civil rights organization dedicated to economic empowerment in order to elevate the standard of living in historically underserved urban communities. Access to affordable, quality health care is one of the four cornerstones and guiding principles of the Urban League's Opportunity Compact. Established in 1910, the Urban League now spearheads the non-partisan efforts of its local affiliates to eliminate disparities that negatively impact health outcomes for African Americans. It has advanced these goals through the development of direct services such as preventive health care and health education programs, through public policy research and through advocacy. Today, there are nearly 100 affiliates in 36 states and the District of Columbia, providing direct services that impact and improve the lives of more than 2 million people nationwide.

57. *National Women's Law Center*
The National Women's Law Center (NWLC) is a nonprofit legal advocacy organization dedicated to the advancement and protection of women's legal rights since its founding in 1972. NWLC has long sought to ensure that women have access to comprehensive, affordable health coverage, including through Medicaid. Women make-up about three-quarters of Medicaid's non-elderly adult beneficiaries, and more than one in ten women receives coverage through Medicaid. NWLC is profoundly concerned about the impact that the Court's decision may have on low-income women's access to health insurance and to other Spending Power laws important to women.

58. *North American Council on Adoptable Children*
Founded in 1974 by adoptive parents, the North American Council on Adoptable Children (NACAC) is committed to meeting the needs of tens of thousands of waiting children who cannot remain with their birth families and the families who adopt them. NACAC provides support and training to adoptive, foster, and kinship parents and identifies and advocates for policies designed to achieve permanence for foster children. NACAC is concerned about preserving Congress' ability to appropriate funding to the States under Title IV-B (child welfare services, promoting safe and stable families) and Title IV-E (foster, kinship care and adoption assistance) of the Social Security Act.

59. *OMNI Behavioral Health*

OMNI Behavioral Health is a nonprofit corporation that provides mental health care to children and adolescents who have serious emotional and behavioral difficulties, and their families; serves adults with intellectual disabilities; and provides therapeutic services to people with eating disorders throughout the Eastern and Central regions of Nebraska. OMNI's clients benefit from the critical mental health care services made available to them through Medicaid, as well as from many other federally funded, locally administered programs, including services provided pursuant to the Individuals with Disabilities Education Act (IDEA); Title I of the Elementary and Secondary Education Act; and the federal foster care and child support enforcement programs (Titles IV-E and IV-D of the Social Security Act).

60. *PACER Center*

PACER Center is a parent training and information center for families of children and youth with all disabilities from birth through 21 years old. Located in Minneapolis, it serves families across the nation, and more than 175,000 families in Minnesota. PACER Center works to expand opportunities and enhance the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents. PACER Center provides publications, workshops, and other resources on education, vocational training, employment, and other services for children with disabilities. PACER Center is interested in preserving Congress' Spending Clause powers because of the vital importance of federal funding for programs that support families with children with disabilities.

61. *Paralyzed Veterans of America*
The Paralyzed Veterans of America (PVA) is a congressionally chartered veterans' service organization founded in 1946 with more than 20,000 members, all of whom are veterans of the armed forces with spinal cord injury or dysfunction. PVA has developed a unique expertise on a wide variety of issues involving the special needs of its members and uses that expertise to be the leading advocate for civil rights and opportunities which maximize the independence of our members. Virtually all PVA members use wheelchairs for mobility and have a significant interest in equal access to affordable health care and the broadest possible implementation of the Affordable Care Act.

62. *Partnerships for Action, Voices for Empowerment*
Partnerships for Action, Voices for Empowerment (PAVE) is a nonprofit, parent-directed organization based in Tacoma, Washington that offers training and information parents need to work with special education professionals in meeting the early intervention and special needs of children with disabilities. PAVE cares deeply about the need to ensure that everyone has appropriate access to healthcare resources, regardless of income. PAVE is also deeply concerned about maintaining federal funding for public education, and supports and services for children with disabilities, through the Individuals with Disabilities Education Act (IDEA); the Elementary

and Secondary Education Act (ESEA), recently reauthorized in the No Child Left Behind Act.

63. *Public Education Network*
Public Education Network (PEN) is a national association of local education funds (LEFs) and individuals working to advance public school reform in low-income communities across our country. PEN serves 12 million students in the United States, or 24 percent of America's public school population. PEN supports the federal government's ability to ensure equity and adequacy of educational opportunity for all, including by granting aid to the States in pursuit of national interests in public education under the Individuals with Disabilities in Education Act and the Elementary and Secondary Education Act.

64. *Resources for Human Development, Inc.*
Resources for Human Development, Inc. (RHD) is a comprehensive, nonprofit, social service organization with headquarters in Philadelphia. Founded in 1970, RHD oversees and supports more than 160 locally managed human service programs in 14 states, including in the areas of behavioral health, addiction recovery, intellectual disabilities, trauma-recovery support and other services for combat veterans, homeless shelters, health care, and employment services. RHD clients benefit from the critical health care services made available to them through Medicaid, as well as from many other federally funded, locally administered programs, including services provided pursuant to the Individuals with Disabilities Education Act (IDEA); Title I of the Elementary and Secondary Education Act; Titles IV-E and IV-D of

the Social Security Act, and the Workplace Investment Act.

65. *Restoration Society, Inc.*
Restoration Society, Inc. (RSI) is a peer-run agency that operates a recovery center, the WNY Empowerment Network. The Network provides many services, including experiential activities and vocational supports that help individuals gain and maintain employment and/or volunteer positions; parenting support and educational opportunities; financial literacy services; family support; home ownership; peer support and self-help; literacy training; educational support; crisis support; recovery planning; and skills and resources development. RSI supports the Affordable Care Act's expansion of Medicaid eligibility as a crucial mechanism for meeting the mental health care needs of millions of Americans living in poverty.

66. *San Francisco AIDS Foundation*
Through education, advocacy and direct services for prevention and care, the San Francisco AIDS Foundation is confronting HIV in communities most vulnerable to the disease. Established in 1982, the Foundation's mission is to radically reduce the rate of new infections in San Francisco, where the AIDS epidemic began, and eventually, everywhere. The Foundation supports the expansion of Medicaid eligibility as an essential step toward ensuring adequate medical care and access to medication for low-income people with HIV and AIDS.

67. *School Social Work Association of America*
The School Social Work Association of America (SSWAA) promotes the profession of school social work to enhance the educational experiences of students and their families. SSWAA achieves this mission by offering continuing professional development, by supporting the effectiveness of school social work services through research and evaluation, and through strong public policy advocacy. SSWAA supports school social workers in creating linkages among schools, families, and communities to address barriers to student success. SSWAA members serve the mental health needs of students and families through early identification, prevention, intervention, counseling, and support. Medicaid funding and services provide a critical line of support in addressing the needs of these families in their schools and communities.

68. *Southwest Behavioral Health Services*
Southwest Behavioral Health Services (SBHS) is one of the largest nonprofit behavioral health organizations in Arizona. The organization's mission is to provide the highest quality, person-centered and community-based services that will promote health, wellness and community integration for a very high risk group of citizens in Arizona. Annually, SBHS provides approximately 12,000 persons with services in the areas of housing, residential care, crisis intervention and stabilization, homeless outreach, case management, psychiatric services and intensive outpatient services. SBHS supports the Affordable Care Act's expansion of Medicaid eligibility: Medicaid reimbursements the federal government funnels

through the States to provider organizations and persons served are essential to reducing the long-term costs of health care and providing care to vulnerable populations.

69. *Specialized Training Of Military Parents*
Specialized Training Of Military Parents (STOMP) is a federally funded Parent Training and Information (PTI) Center established to assist military families who have children with special education or health needs. STOMP cares deeply about the need to ensure that everyone has appropriate access to healthcare resources, regardless of income. STOMP is also deeply concerned about maintaining federal funding for public education, and supports and services for children with disabilities, through the Individuals with Disabilities Education Act (IDEA); the Elementary and Secondary Education Act (ESEA), recently reauthorized in the No Child Left Behind Act.

70. *Thresholds*
The Thresholds is an Illinois not-for-profit corporation that provides a variety of psychiatric rehabilitation and recovery services to people with severe and persistent mental illnesses. Thresholds is the largest not-for-profit provider of mental health services in the Chicagoland area, serving 5,000 persons annually. Services include day programs, community based outreach programs, employment support and placement, and residential housing. The Affordable Care Act's expansion of Medicaid eligibility ensures that those with the greatest mental health needs are able to access services without having to first

receive a disability determination from Social Security.

71. *United Spinal Association*
United Spinal Association is the largest nonprofit organization dedicated to helping people living with spinal cord injuries and disorders. United Spinal provides active-lifestyle information, peer support, and advocacy to empower its 35,000 members and others to achieve their highest potential in all facets of life. Its public policy initiatives focus on expanding education and employment, promoting community integration, and enforcing accessibility and nondiscrimination statutes. United Spinal Association is interested in preserving and expanding the availability of Medicaid to help its low-income members live full lives in their own homes.

72. *U.S. Psychiatric Rehabilitation Association*
With approximately 1,400 members, the U.S. Psychiatric Rehabilitation Association (USPRA) is the preeminent association advancing the practice of psychiatric rehabilitation and recovery in the United States. USPRA and its members developed and defined the practice of psychosocial/psychiatric rehabilitation, establishing these services as integral to community-based treatment and leading the recovery movement. Psychiatric rehabilitation services are essential for keeping individuals with mental illnesses off the streets and out of detention centers and hospital emergency rooms. For this reason, USPRA has long advocated for the expansion of Medicaid eligibility to millions of low-income Americans who are currently uninsured.

73. *Vet to Vet*

Vet to Vet is a consumer/provider partnership program in which veterans with mental illness or psychiatric conditions who are in recovery work to help other veterans in a peer-counseling capacity. Vet to Vet is administered by veterans who themselves have been consumers of Veterans' Administration mental health services. Vet to Vet provides a six-week, peer-facilitator training program that teaches veterans how to facilitate peer group sessions and introduce program learning topics. Many veterans and their families rely on Medicaid, and Vet to Vet has a strong interest in equal access to affordable healthcare and the broadest possible implementation of the Affordable Care Act.

74. *Vinfen*

Vinfen is a private nonprofit human services organization that provides a comprehensive array of services to adults with psychiatric and developmental disabilities. Vinfen is the largest contractor providing Department of Mental Health services in Massachusetts, is involved in numerous state provider and advocacy organizations, and in a wide range of policy planning activities in Massachusetts and Connecticut. Vinfen is able to meet the mental health care needs of many of its clients because of Medicaid, and is deeply committed to the preservation and expansion of the Medicaid program.

75. *Voice for Adoption*

Voice for Adoption (VFA) is a membership advocacy organization with a network of grassroots adoption and child welfare advocates throughout the country. VFA develops and advocates for improved adoption policies, and recruits and supports adoptive families. Recognized as a national leader in special-needs adoption, VFA works closely with federal and state legislators to make a difference in the lives of the 107,000 children in foster care who are waiting to be adopted and the families who adopt children from foster care. Voice for Adoption is concerned about preserving Congress' ability to appropriate funding to the States under Title IV-B (child welfare services, promoting safe and stable families) and Title IV-E (foster, kinship care and adoption assistance) of the Social Security Act.

76. *Volunteers of America*
Volunteers of America is a national, faith-based non-profit organization, and one of the largest human services organizations in the country. With nearly 16,000 paid professional employees and 65,000 volunteers, Volunteers of America provides services to more than two million people in more than 400 communities, including at-risk youth; the frail elderly; men and women returning from prison; homeless individuals and families, including veterans; people with disabilities; and those recovering from addictions. Volunteers of America supports the expansion of Medicaid eligibility, which is vitally important for the low-income people the organization serves who are currently uninsured. In addition, Volunteers of America is concerned about the preservation of many other federally funded, locally administered programs that provide critical services to so many families and individuals in need.

77. *Whitman-Walker Clinic, Inc.*
Whitman-Walker Clinic, Inc., doing business as Whitman-Walker Health, is a community-based, nonprofit health care center offering primary medical care and HIV/AIDS specialty care; mental health and addiction treatment services; dental care; medical adherence case management; testing and prevention services for HIV and sexually transmitted infections; and legal services to residents of the District of Columbia and the greater Washington metropolitan area. Many of Whitman Walker's patients and clients are un- or underinsured. The expansion of the Medicaid program under the Affordable Care Act is a major step forward in ensuring adequate access to medical care for this population, and to relieving the crushing financial burden on community health centers and other institutions that provide uncompensated care to substantial numbers of individuals and families without adequate insurance.

78. *Women's Sports Foundation*
The Women's Sports Foundation (WSF) is a nonprofit educational organization dedicated to expanding opportunities for girls and women to participate in sports and fitness and to creating an educated public that supports gender equity in sports. The WSF distributes hundreds of thousands of dollars a year in grants and scholarships to female athletes and girls' sports programs, answers thousands of inquiries per year concerning Title IX and other women's sports-related questions, and administers award programs to increase public awareness about the achievements of girls and women in sports. WSF is deeply committed to preserving the federal government's

ability to encourage the equitable participation of girls and young women in school sports teams through Title IX of the Education Amendments of 1972.

79. *YWCA USA*

YWCA USA is a national nonprofit women's organization dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all. The YWCA represents more than two million women and girls, and serves thousands of women, girls, and their families annually through a variety of programs and services, including violence prevention and recovery programs, housing programs, job training services, and more. YWCA's clients include women and girls escaping violence, low-income women and children, elderly women, disabled women, homeless women, and families. The organization is interested in the preservation and expansion of the Medicaid program because it provides healthcare for millions of women and girls across our country, including YWCA clients.

AMICUS
CURIAE
BRIEF

No. 11-400

IN THE

Supreme Court of the United States

STATE OF FLORIDA, *et al.*,
Petitioners,
v.
UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF SERVICE EMPLOYEES INTERNATIONAL UNION AND CHANGE TO WIN AS *AMICI CURIAE* SUPPORTING RESPONDENTS AND SUGGESTING AFFIRMANCE ON THE MEDICAID ISSUE

JUDITH A. SCOTT
WALTER KAMIAT
MARK SCHNEIDER
Service Employees
International Union
1800 Massachusetts Ave., N.W.
Washington, D.C. 20036
Tel: (202) 730-7455

Counsel for Amicus Curiae
Service Employees
International Union

STEPHEN P. BERZON
Counsel of Record
SCOTT A. KRONLAND
MATTHEW J. MURRAY
Altshuler Berzon LLP
177 Post Street, Suite 300
San Francisco, CA 94108
Tel: (415) 421-7151
sberzon@altshulerberzon.com
Counsel for Amici Curiae
Service Employees
International Union and
Change to Win

[Additional Counsel on Inside Cover]

February 17, 2012

Peake DeLancey Printers, LLC - (301) 341-4600 - Cheverly MD

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INTEREST OF *AMICI CURIAE*

Amicus curiae Service Employees International Union ("SEIU") is the nation's largest healthcare union, with more than half its 2.1 million members in the healthcare field, many of whom provide care under the federal Medicaid program.

Amicus curiae Change to Win is a federation of four labor unions — the International Brotherhood of Teamsters, United Farm Workers of America, United Food and Commercial Workers International Union, and SEIU — which collectively represent 5.5 million working men and women. Change to Win and SEIU are committed to achieving affordable healthcare for all workers and their families.[1]

SUMMARY OF ARGUMENT

Petitioners do not question the constitutionality of the existing Medicaid conditional spending program. They challenge only its expansion.[2] Yet they fail to identify any constitutionally relevant and judicially manageable distinction between the pre-existing federal spending program they desire to continue and the expanded program they challenge.

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[1] No counsel for a party authored this brief in whole or in part, and no person other than *amici* or their counsel made a monetary contribution to the preparation or submission of this brief. The parties have filed letters of consent with the Clerk of the Court.

[2] The Medicaid expansion comprises portions of Title II of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (hereinafter "ACA").

1. Petitioners' challenge does not present the type of potential concern with impermissible "coercion" discussed in dicta in *South Dakota v Dole*, 483 U.S. 203 (1987), or the type at issue in *New York v. United States*, 505 U.S. 144 (1992).

In *Dole*, the Court discussed in dicta the possibility that in some circumstances Congressional actions associated with a spending power program *might* be limited by a concern that Congress not impermissibly "coerce" the States. The potential concern with coercion at issue there, however, was not with spending conditions that, like those at issue here, simply describe the types of programs that federal funds may be used to support. Rather, the concern in *Dole* was with Congress' conditioning receipt of federal funds on a requirement that the States act *outside the scope* of the federally-subsidized program itself. Nonetheless, no federal court has ever struck down a federal spending condition on such grounds. The Court need not decide here whether there might be some extreme circumstance in which such a "coercion" challenge to a measure associated with a spending program might be viable. Petitioners' challenge here goes directly to Congress' fundamental decision to expand the Medicaid program, not to a condition outside the scope of the program.

Nor does Petitioners' challenge implicate the "coercion" issue presented in *New York*, where Congress imposed burdens directly on States that opted out of a federal program. The ACA does not impose requirements on States that choose to opt out of Medicaid.

2. a. Petitioners' allegation that Congress assumed no State would opt out of Medicaid does not make the Medicaid expansion unconstitutionally coercive. The Court rejected a similar argument in *Dole*, and with good reason. Whatever Congress may have assumed about the attractiveness of the deal it has offered here, the "ultimate decision" whether to participate in Medicaid rests, as it always has, with the States. *New York*, 505 U.S. at 168.

Medicaid provides the States substantial federal subsidies and significant flexibility to design and administer healthcare programs — and it will continue to do so after the expansion. Congress thus had every reason to expect the States would continue their long-standing participation in the program.

In any event, Petitioners are wrong that the structure of the ACA necessarily reflects a congressional assumption that every State would participate. The ACA offers subsidies to Medicaid-eligible individuals above the federal poverty line so they can purchase affordable insurance; Medicaid is not their only alternative. And the minimum coverage provision (which Petitioners fundamentally misconstrue) will have no effect on most individuals below the federal poverty line. Any political pressure on the States to opt in to Medicaid that might flow from the possibility of that provision resulting in a modest federal tax increase on some subset of the Medicaid-eligible population pales in comparison to analogous pressure created by the conditional federal tax upheld in *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937).

b. Ultimately, Petitioners' challenge rests on the contention that the Medicaid expansion is impermissibly "coercive" because Medicaid is just too large, important, and generous for the States to decline to participate. But this argument fundamentally misconceives the breadth of Congress' spending powers to address important social problems. The logic of Petitioners' argument would lead to the perverse result that the larger and more important the social problem Congress seeks to address, the more popular and effective Congress' design proves to be, and the more that States find that solution to benefit their citizens, the more constitutionally suspect the program would become.

Congress has exclusive control over federal funds, U.S. Const. Art. I, §9, Cl. 7, and full authority to spend those funds to promote its reasonable conception of the "general Welfare," *id.* Art. I, §8, Cl. 1. Congress could have chosen to establish a single national health insurance program to provide coverage for low-income individuals directly, and it could replace the current federal-state Medicaid program with an exclusively federal program. By pursuing a "cooperative federalism" approach to solving social problems, and thereby offering the States more flexibility and control, Congress does not forfeit its constitutional authority to address problems of national importance or its future ability to alter its programs or control federal funds. It should be no surprise, then, that the Court has long rejected challenges to federal funding conditions that simply delineate the scope of programs that Congress is willing to support. *See, e.g., Massachusetts v. Mellon*, 262 U.S. 447, 480 (1923); *Oklahoma v. United States Civ. Serv. Comm'n*, 330 U.S. 127, 143 (1947); *Lau v. Nichols*, 414 U.S. 563, 569 (1974).

Moreover, not only do Petitioners' arguments find no support in the text or structure of the Constitution, but accepting them would force the judiciary to become enmeshed in political and policy judgments. The "discretion" to determine what kinds of programs best promote the general welfare rests with Congress, not the courts or the States. *Helvering v. Davis*, 301 U.S. 619, 640, 645 (1937). It would be beyond the proper judicial role for the courts to decree that a program which Congress has chosen to fund only if operated in an integrated fashion must instead be separated into smaller parts, with Congress required to fund them in isolation over its express objection.

Although Petitioners disclaim any "vested" right to "pre-existing" Medicaid funding, that is the essence of their challenge. They effectively argue that the States have become so dependent on the old Medicaid program that Congress may no longer expand it. But the States cannot compel the use of federal funds on terms other than those Congress has prescribed. And Congress' authority to define the scope of the programs it is willing to support cannot constitutionally be limited by the fact that a past Congress supported certain programs that have become large and popular: "'One legislature . . . cannot abridge the powers of a succeeding legislature.'" *Lockhart v. United States*, 546 U.S. 142, 147 (2005) (Scalia, J., concurring) (quoting *Fletcher v. Peck*, 6 Cranch 87, 135 (1810)).

In enacting the Medicaid expansion in question, Congress has done nothing more than expand the scope of an existing federal program. No constitutional principle precludes Congress from doing so.

ARGUMENT

Petitioners do not question the constitutionality of the pre-existing Medicaid conditional spending program. Indeed, not only is it settled law that Congress may grant money to the States on condition that it be used to support programs that meet federal parameters,[3] but the remedy Petitioners seek is for the Court to force Congress to continue to fund the pre-existing Medicaid program rather than the expanded Medicaid program that Congress has now decided is necessary to serve the "general Welfare." U.S. Const. Art. 1, §8, cl. 1.

That being so, Petitioners' argument that the Medicaid expansion is unconstitutionally "coercive" requires them to identify some constitutionally relevant and judicially manageable distinction between the pre-existing federal spending program and the expanded program they challenge. This they fail to do.

Moreover, Petitioners' challenge to the expanded program goes directly to Congress' power to spend federal money on those programs (and only those programs) that Congress deems worthy of support.

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[3] *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006); *New York v. United States*, 505 U.S. 144, 167 (1992); *South Dakota v. Dole*, 483 U.S. 203, 206 (1987).

Congress operates at the zenith of its powers and competence when it decides on the scope of a federal spending program — and the vision of the "general Welfare" reflected in such a program — that will be funded from the federal Treasury. The desire of some States to be offered federal money for a more limited program, or on a more flexible "pick and choose" basis, ultimately presents a political and policy issue for Congress and those States, not one subject to judicial intervention.

I. PETITIONERS' CHALLENGE TO THE MEDICAID EXPANSION DOES NOT IMPLICATE THE POTENTIAL CONCERNS WITH IMPERMISSIBLE "COERCION" DISCUSSED IN *DOLE* AND *NEW YORK*

As an initial matter, Petitioners' challenge rests almost entirely on dicta in *South Dakota v. Dole*, 483 U.S. 203, 211 (1987), which quoted dicta in *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937), suggesting that Congress' spending power might in some circumstances be limited by a concern that it not be used to impermissibly "coerce" the States. Petitioners also point to the Court's reference to impermissible coercion in *New York v. United States*, 505 U.S. 144, 169, 175 (1992), and argue that, if the Medicaid expansion does not represent an impermissibly "coercive" exercise of the spending power, "no Act of Congress ever will." Pet. Br. 21, 32, 52-53. But the types of potentially impermissible "coercion" discussed in those cases are not even at issue here. While accepting Petitioners' theories would undermine the most basic prerogatives reserved to Congress by the Constitution, rejecting

Petitioners' challenge would not affect the possible viability of the kinds of challenges to federal statutes raised in those cases.

1. In *Dole*, the Court rejected a challenge to a federal statute that required withholding of a portion of federal highway funding to any State that did not enact a state-wide 21-year-old drinking age. *Dole*, 483 U.S. at 205. Although the drinking-age condition "related to one of the main *purposes* for which highway funds are expended — safe interstate travel," *id.* at 208 (emphasis added) — the condition did not set a requirement for the actual projects on which Congress would expend federal funds: the design, construction, and maintenance of particular highways. Rather, through the condition, Congress sought to leverage the States' interest in federal highway money to induce the States to adopt a regulation *outside* the scope of the specific transportation projects federal moneys would directly support.

It was in that context that the Court in *Dole*, while reaffirming Congress' well-settled authority to "act[] indirectly under its spending power to encourage" the States to adopt regulations, also held open the possibility that "in *some circumstances* the financial inducement offered by Congress *might* be so coercive as to pass the point at which 'pressure turns into compulsion.'" *Id.* at 206, 211 (quoting *Steward Machine*, 301 U.S at 590 (emphases added)). But the Court concluded that Congress' conditioning of five percent of federal highway funds on the drinking-age requirement did not raise such a potential coercion issue, and therefore did not discuss the issue further. *Id.*[4]

In *Steward Machine*, the Court had also left open the possibility of impermissible coercion where conditions are imposed *outside* the scope of the federal program. The Court there rejected a challenge to a federal tax on employers that provided a 90% credit in States that adopted unemployment insurance programs meeting federal specifications. *Steward Machine*, 301 U.S. at 574. The Court questioned whether the concept of impermissible "coercion" through the offer of conditional funds "can *ever* be applied with fitness to the relations between state and nation." *Id.* at 590 (emphasis added). But while stressing that, in the case before it, the Court saw "[n]othing . . . suggest[ing]" impermissible "coercion," it made clear that it was not reaching the question whether a federal tax would be valid "if it [were] laid upon the condition that a state may escape its operation through the adoption of a statute *unrelated* in subject-matter to activities fairly within the scope of national policy and power." *Id.* (emphasis added).

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[4] Justice O'Connor's dissent makes clear that *Dole* was focused on conditions *outside* the scope of programs supported by federal funds. Justice O'Connor saw a threat to state autonomy in permitting Congress "to insist as a condition of the use of highway funds that the State impose or change regulations in *other areas* of the State's social and economic life because of *an attenuated or tangential relationship* to highway use or safety." *Dole*, 483 U.S. at 215 (O'Connor, J., dissenting) (emphases added). She would have avoided that threat by holding similar conditions categorically outside Congress' spending power, upholding only conditions that "*specif[y] in some way how the money should be spent*, so that Congress' intent in making the grant will be effectuated." *Id.* at 216 (O'Connor, J., dissenting) (emphasis added) (internal quotation marks omitted).

No federal court has ever struck down a Spending Clause statute on the ground that it impermissibly "coerces" the States. While Petitioners here cite *Dole*, their challenge here does not in any sense implicate the potential concern *Dole* raised. Petitioners are not challenging a requirement that to receive Medicaid funding they must engage in some activity or adopt some regulation outside the scope of Medicaid. Rather, they are challenging Congress' fundamental decision to expand the scope of the federal Medicaid program itself, seeking directly to limit the discretion of Congress regarding how federal money should be spent.

The Court has elsewhere noted a fundamental distinction between, on the one hand, Congress' clear right to limit the types of programs that will be supported by federal funds, and on the other, congressional efforts that "effectively prohibit[] the recipient from engaging in . . . protected conduct *outside the scope of the federally funded program.*" *Rust v. Sullivan*, 500 U.S. 173, 197 (1991) (emphasis added). The same conceptual distinction separates the conditions at issue here from those conditions that might raise *Dole*'s concern with potentially impermissible coercion.

As relevant here, the Medicaid expansion raises Medicaid's minimum eligibility requirements, for States that choose to participate, to include coverage of non-disabled adults under age 65 with incomes below roughly 138% of the federal poverty line. *See* 42 U.S.C. §1396a(a)(10)(A)(i)(VIII) (eligibility expanded to 133% of poverty line); *id.* §1396a(e)(14)(I) (5% income disregard). By establishing such minimum requirements, Congress has done nothing more than exercise its constitutional authority to "define the limits" of programs that it will pay for with federal funds. *Rust*, 500 U.S. at 194.

Moreover, Congress' changes here are not different in kind from Congress' changes to Medicaid in the past. Congress has always established minimum eligibility requirements for state Medicaid plans. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Harris v. McRae*, 448 U.S. 297, 308 (1980). As Petitioners acknowledge, Congress has repeatedly amended such minimum requirements over time. Pet. Br. 5-6. The amendment Petitioners challenge is not different in any relevant respect.

Likewise, the maintenance-of-effort provision, 42 U.S.C. §1396a(gg), does not require States to act in any area *outside the scope* of the federally-subsidized Medicaid program. Rather, as it repeatedly has in the past, Congress has simply described the kinds of programs that may be funded from the federal Treasury (i.e., programs in which participating States do not reduce their current levels of service in the short term).

None of these aspects of the Medicaid expansion involves conditions on state receipt of federal funds that are "attenuated or tangential" to how the federal money is to be spent. *Dole*, 483 U.S. at 215

(O'Connor, J., dissenting). They thus have nothing to do with the potential concern with impermissible coercion held open in *Dole*.[5]

2. Petitioners' challenge to the Medicaid expansion also does not implicate the concern with "commandeering" of state authority at issue in *New York*. In that case, Congress commanded the States either to regulate radioactive waste according to Congress' specifications or to "take title" to, and assume legal liability for, radioactive waste produced within their borders. *New York*, 505 U.S. at 153. The Court held the "take title" provision to be unconstitutionally coercive because, under that provision, "[n]o matter which path the State chooses, it must follow the direction of Congress." *Id.* at 177.

Here, by contrast, Congress has not legally compelled the States to do anything. Petitioners argue that the ACA "effectively order[s]" each State either to opt in to Medicaid or to "assum[e] the full burden of its neediest residents' medical costs." Pet. Br. 23,

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[5] This case also does not implicate a different (though arguably related) potential concern with improper "coercion" that has been suggested in dicta by one lower court. *Cf. Virginia Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (4th Cir. 1997) (en banc) (plurality opinion of Luttig, J.). That concern focused on the possibility of the federal government withholding all funding in a Spending Clause program based on a truly "insubstantial" state violation of minimum requirements set by Congress. *Id.* Petitioners' argument here is not that Congress is using the elephant of federal Medicaid funding as leverage to go after a mouse, but that they object to Congress' fundamental decision to redirect federal Medicaid spending towards accomplishing a revised and expanded purpose.

52. Not so. While a State may feel a moral or political impetus to provide or subsidize healthcare for low-income individuals if it declines to participate in Medicaid, Congress has not *compelled* it to do so, and Congress certainly has not compelled it to provide *any particular level* of healthcare services, or *any particular method* of delivering them. A State that opts out of Medicaid would have full freedom to decide the nature of the "burden," if any, that it wishes to "assum[e]" regarding healthcare for previously Medicaid-eligible individuals. Pet. Br. 23.

As this Court has repeatedly recognized, there is a basic difference between a direct command requiring the States to act and a conditional offer of federal funds encouraging them to do so. *See New York*, 505 U.S. at 168; *College Sav. Bank v. Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 687 (1999); *Printz v. United States*, 521 U.S. 898, 917-18 (1997). Petitioners' protests notwithstanding, Congress has not ordered the States to do anything with respect to healthcare, and thus the coercion concern discussed in *New York* is not implicated.

What Petitioners complain of as improperly "coercive," therefore, is quite distinct from what was at issue in any of the prior cases on which they rely. Petitioners here complain of nothing beyond an exercise by Congress of its undisputed authority to design a federal spending program to further an entirely legitimate vision of the "general Welfare" that Congress believed merits a substantial outlay of federal funds.

II. THE FEATURES THAT PETITIONERS IDENTIFY DO NOT MAKE THE MEDICAID EXPANSION UNCONSTITUTIONALLY COERCIVE

Unable to rely on precedent, Petitioners point to several features of the ACA as supposedly justifying court intervention to check the power of Congress to expand Medicaid. But they fail to identify in those features any constitutionally relevant or judicially manageable principle for fashioning a new limit on Congress' authority to determine the kinds of spending programs it is willing to subsidize with federal funds.[6]

A. Petitioners' allegation that Congress assumed that no State would opt out of Medicaid does not make the expansion unconstitutional; nor does the ACA necessarily reflect any such assumption.

Petitioners dedicate much of their brief to arguing that Congress in adopting the ACA *assumed* no State would opt out of Medicaid. Pet. Br. 22-23, 33-39. According to Petitioners, that alleged assumption "is all the proof the Court should need to find the Act unconstitutionally coercive." Pet. Br. 39; *see also id.* at 55. This argument falls apart upon examination.

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[6] Petitioners raise the specter of an "unlimited spending power" (Pet. Br. 28, 29; *see also id.* at 21), but rejecting their challenge does not lead to such a result. There is no dispute that federal funding program conditions on States must (a) promote the "general welfare," (b) be stated "unambiguously," (c) relate "to the federal interest in particular national projects or programs," and (d) not "induce the States to engage in activities that would themselves be unconstitutional." *Dole*, 483 U.S. at 207-08, 210 (internal quotation marks omitted). The Medicaid expansion satisfies each of these requirements.

1. Petitioners' argument here is strikingly similar to an argument that this Court has previously rejected as both logically and legally faulty — that a record of widespread state participation in a federal spending program is somehow evidence of impermissible "coercion." To accept such an argument, the *Dole* Court explained, would be to find that "a conditional grant of federal money . . . is unconstitutional simply by reason of its success in achieving the congressional objective." *Dole,* 483 U.S. at 211.

Perhaps recognizing that precedent and logic foreclose any impermissible "coercion" argument based on the actual record of universal participation by the States in Medicaid, Petitioners argue that Congress acted unconstitutionally because it supposedly *assumed* that the States' uniform participation would continue after the expansion. As we shall explain, Petitioners are wrong that the ACA necessarily reflects such a congressional assumption. *See* pp. 18-20, *infra.* But even if it did, such an assumption would not change the fact that, as a legal matter, the "ultimate decision" whether to participate in Medicaid rests, as it always has, with the States. *New York,* 505 U.S. at 167-68.

In any case, there are perfectly legitimate reasons why Congress might have assumed full state participation. The expanded Medicaid program offers the States billions of dollars in federal money to pay for providing services that state residents generally regard as vitally important: healthcare for low-income populations. The high percentage of Medicaid expenses covered by the federal Treasury – 50% to 83% generally, 42 U.S.C. §1396d(b), and 90% to 100% of expenditures for "newly eligible" individuals under the expansion, *id.* §1396d(y) – reflects the attractive nature of the arrangement offered to the States. Put simply, by accepting these lucrative grants of federal aid, the States are able to deliver valuable services to their citizens far more efficiently and at a small fraction of the cost of those services. That reality explains why all States participated in Medicaid prior to the expansion, and why it was reasonable for Congress to expect such universal participation to continue after the expansion, especially since the expansion would greatly increase the percentage of Medicaid expenses that would be federally subsidized.

Moreover, the substantial leeway the States themselves have always had in determining the structure and design of their state Medicaid programs will continue under expanded Medicaid. While Petitioners emphasize the federal minimum standards that limit state Medicaid programs, they ignore that States retain substantial freedom to choose how to define and design their own (highly federally subsidized) state Medicaid programs to better meet their citizens' needs.[7]

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[7] *See, e.g.*, 42 U.S.C. §1396a(a)(10)(A)(ii), (C) (state options to cover additional populations and additional services beyond federal minimums, generally at the same rate of federal reimbursement); *id.* §1396a(a)(17) (state flexibility to set stan-

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Given all this, Congress had little reason when it enacted the Medicaid expansion to adopt a "contingency plan" (Pet. Br. 38) to address issues that might arise if a State were to opt out of Medicaid in reaction to the expansion — especially when the expansion would not take effect until January 1, 2014. *See* 42

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dards for amount, duration, and scope of services to cover); *id.* §1396a(a)(30)(A) (state flexibility to set provider rates); *id.* §§1396a(k)(1), 1396u-7(b) (state flexibility to design benefits packages for newly eligible individuals by providing "benchmark," "benchmark-equivalent," or expanded coverage); *id.* §1315 (waivers of most Medicaid Act provisions to facilitate state "demonstration" projects); *id.* §1396n(b) (waivers granting States flexibility to provide services through managed care delivery systems or otherwise select and set standards for providers); *id.* §1396n(c)-(d) (waivers granting States flexibility regarding coverage of home and community-based services); *id.* §1396n(e) (same regarding coverage of services for young children with certain conditions); *id.* §1396n(g) (state flexibility regarding coverage of case management services); *id.* §1396n(i) (state option to cover medical assistance for home and community-based services for elderly and disabled individuals); *see generally* Kaiser Commission on Medicaid and the Uninsured, *Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues* (April 2011), http://www.kff.org/medicaid/upload/8174.pdf (describing state options regarding eligibility, benefits and cost-sharing, care delivery and provider payment, long-term services and supports, and care of individuals eligible for both Medicaid and Medicare); U.S. Dep't of Health & Human Servs., *Letter of the Secretary on State Flexibility and Federal Support Available for Medicaid* (Feb. 3, 2011), www.hhs.gov/news/press/2011pres/01/20110203c.html.

U.S.C. §1396a(a)(10)(A)(i)(VIII).[8] Congress had (and has) plenty of time to respond with possible further legislation should one or more States in the future choose to opt out of Medicaid or express a serious intention to do so. Indeed, should States actually withdraw from or threaten to withdraw from the expanded Medicaid program, Congress would be far better able to determine at that point what appropriate actions to take.

2. In any event, even if it were relevant (and it is not), Petitioners are wrong in their threshold premise that the structure of the ACA necessarily reflects a Congressional assumption that every State would opt in to Medicaid. To support this contention, Petitioners primarily point to the fact that that the ACA includes a minimum coverage provision, 26 U.S.C. §5000A(a)-(b), yet the ACA (they assert) "provid[es] no alternative to Medicaid for the most needy" to comply with that provision. Pet. Br. 22. Not so.

Congress did, in fact, provide alternatives for many of the most needy who would lose coverage if a State withdrew from Medicaid. In particular, Congress provided income tax credits and authorized federal payments to insurers so that individuals with income between 100% and 138% of the federal poverty line could purchase affordable health insurance, even though those same individuals would be eligible for Medicaid under the expansion if their State chose to participate. *See* 26 U.S.C. §36B(a), (b)(3); 42 U.S.C. §18071(c)(2)-(3).

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[8] The Medicaid expansion Petitioners challenge does not impermissibly impose "retroactive conditions." Pet. Br. 45 n.17. Rather, the new requirements apply only prospectively to new grants, which the States are free to accept or decline. *Contrast Bennet v. New Jersey*, 470 U.S. 632, 638 (1985).

Petitioners gloss over this population, and focus instead on individuals below the federal poverty line. Pet. Br. 36. But Petitioners also ignore that the vast majority of these individuals will not be subject to the minimum coverage penalty in any case. The minimum coverage provision does nothing other than state a condition predicate for imposition of a tax penalty on certain federal income *taxpayers* (who do not obtain "minimum essential" insurance coverage). 26 U.S.C. §5000A(a)-(b).[9] Were any State to opt out of Medicaid, the vast majority of its Medicaid-eligible residents with income below the federal poverty line would be unaffected by this penalty, because they do not earn income in excess of the federal income tax filing threshold. *See id.* §5000A(e)(2).[10] And those within the small sliver of the population with income

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[9] *See* U.S. Medicaid Br. 49-50; U.S. Minimum Coverage Br. 20-21, 52-56, 60-62; Br. of SEIU and Change to Win as *Amici Curiae* Addressing the Minimum Coverage Provision 2, 4-7, 11-15.

[10] In 2011, the federal income tax filing threshold for an individual under age 65 was $9,500, just modestly below the $10,890 federal poverty line for an individual (outside Alaska and Hawaii); the filing threshold for a married couple of two under 65 filing jointly was $19,000, well above the $14,710 federal poverty line for a family of the same size (outside Alaska and Hawaii). *See* IRS, *Publication 501: Exemptions, Standard Deduction, and Filing Information* 2-3 & Tbl. 1

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above the filing threshold but still below the federal poverty line also would almost assuredly be unaffected. Some might be covered by policies offered by their employers, *id.* §5000A(f)(1)(B), or obtained by their parents, 42 U.S.C. §1396gg-14 (requiring insurers to extend dependent coverage up to age 26). Even those without such coverage would likely be unaffected by the minimum coverage provision because it creates no tax penalty unless minimum essential health insurance is available for purchase at eight percent or less of a taxpayer's income, 26 U.S.C. §5000A(e)(1), which would be exceedingly unlikely for individuals with such low earnings.[11] Moreover, even if such inexpensive insurance were available, these individuals could apply to the Secretary of Health and Human Services for "hardship" waivers. *Id.* §5000A(e)(5). A State's decision to opt out of Medicaid would no doubt provide a strong case for such waivers.

3. A final point on the minimum coverage provision is in order. Although they do not argue the point

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(2011), http://www.irs.gov/pub/irs-pdf/p501.pdf (filing thresholds); U.S. Dep't of Health & Human Servs., *Annual Update of the HHS Poverty Guidelines*, 76 Fed. Reg. 3637-38 (Jan. 20, 2011) (federal poverty lines).

[11] For example, individuals with income at the 2011 federal poverty line ($10,890 outside Alaska and Hawaii, *see* note 10, *supra*) in States that opt out of Medicaid would be unaffected by the minimum coverage provision, unless minimum essential insurance coverage were available to them at just $72.60 per month or less.

explicitly, Petitioners seem to suggest that any burden placed by the ACA on some subset of Medicaid-eligible citizens as a consequence of their State's withdrawal from Medicaid would somehow constitute a form of impermissible "coercion" of the State. But here, as we have shown, the extent of any such legal burden would be quite modest: giving such individuals a choice between obtaining alternative healthcare coverage (with those above the poverty line granted substantial federal subsidies to assist them) and paying an income tax penalty (with most of the rest falling below the minimum income thresholds for such penalty to apply). In stark contrast, this Court in *Steward Machine* rejected an impermissible "coercion" argument in a context where the burdens on a State's constituents were by any measure far greater.

In that case, Congress exacted a tax *ten times* greater in magnitude on employers in States that chose not to implement an unemployment insurance program meeting federal specifications. *Steward Machine*, 301 U.S. at 574. Yet the Court concluded that the federal statute involved no impermissible "coercion" of the States (*id.* at 589), even though, as Petitioners' concede (Pet. Br. 51), Congress made *no* commitment to provide a federal unemployment insurance system if a State declined to enact one of its own. *See Steward Machine*, 301 U.S. at 574 (proceeds from federal tax "not earmarked in any way"); *id.* at 589 (Congress "retain[ed] undiminished freedom" to spend revenues from the tax "as it pleased"). If the political pressure placed on the States by the conditional federal tax at issue in that case did not cause constitutional concern, the same must be true of any analogous political pressure to opt in to Medicaid caused by the far more modest possible tax consequences of the minimum coverage provision.

B. The scope and importance of Medicaid do not make its expansion unconstitutional.

Because Petitioners' allegation that Congress assumed full state participation in expanded Medicaid does nothing to advance their challenge, Petitioners' case ultimately must rest on their theory that the expansion of Medicaid is unconstitutionally "coercive" because of the "sheer size" and importance of the program. Pet. Br. 39. They argue that Medicaid is so large, important, and popular that States cannot as a practical matter decline to participate. *Id.* at 23, 39-48. Hence, they argue that the expansion is impermissible because Congress cannot condition the "pre-existing" federal Medicaid funding that the States desire (and that the States and their populations have found so beneficial) on the States' acceptance of a larger program. *Id.* at 40. Their argument is untenable.

1. The essential problem with Petitioners' argument is that it fundamentally misconceives the legitimate breadth of Congress' spending powers to address important social problems. The logic of Petitioners' argument also would lead to the truly perverse result that the larger and more important the social problem Congress seeks to address, the more popular and effective Congress' design proves to be, and the more that States find that Congress'

program benefits their citizens, the more constitutionally suspect the program would become.[12] This cannot be the law. Congress has every right (indeed, a solemn responsibility) to spend federal moneys to ameliorate serious social problems. The extent to which Congress succeeds in addressing such problems of national concern simply cannot be a factor leading to the invalidation of federal legislation.

The Constitution's text is unmistakably clear that Congress has the full authority to raise and spend federal funds to serve the "general Welfare of the United States," as Congress reasonably judges that welfare should be served. U.S. Const. Art. I, §8, Cl. 1. Moreover, through the Appropriations Clause, the Constitution separately makes clear that control over the use of federal funds is exclusively the province of Congress acting through federal law. *Id.* Art. I, §9, Cl. 7. That these powers result in substantial federal authority that may reach deeply into American life should be no surprise.[13]

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[12] Although federal subsidies will cover the overwhelming portion of the costs of expanded Medicaid, Petitioners nonetheless complain that States that choose to participate in the expansion will incur some additional costs above those they currently expend. Pet. Br. 16-18. But Petitioners ultimately disclaim that this is the basis for their challenge to the expansion. According to Petitioners, "[c]oercion is measured by how much a State stands to lose if it *rejects* Congress' terms, not by how much it stands to lose if it *accepts* them." *Id.* at 46 (emphases in original). Petitioners recognize they cannot have it both ways: the States cannot complain that Congress has been too generous with federal money for them to turn down the offer, while at the same time complaining that Congress has not been generous enough to States accepting those funds. Petitioners have chosen to attack Medicaid for being too generous, not too miserly.

Congress could have chosen to establish a single national health insurance program to provide coverage for low-income individuals directly — as it has with Medicare for individuals over age 65 (42 U.S.C. §1395 *et seq.*) — rather than structuring Medicaid as "a cooperative federal-state program." *Wilder*, 496 U.S. at 502; *see, e.g.*, *Helvering*, 301 U.S. at 645 (upholding national Old Age Benefits program); *Steward Machine*, 301 U.S. at 588-89 (upholding tax credit scheme based on premise that federal government could enact fully national unemployment insurance program). That Congress has the power to pursue an exclusively federal program to provide for its citizens' healthcare — as an aspect of the "general Welfare" — reflects the unassailable truth that under our Constitution the relationship of the federal government to the citizenry is a "'direct relationship'" of sovereign and citizen, with "'its own privity, its own set of mutual rights and obligations,'" and is not a relationship inherently mediated by the States. *Printz*, 521 U.S. at 920 (quoting *U.S. Term Limits, Inc. v. Thorton*, 514 U.S. 779, 838 (1995) (Kennedy, J., concurring)).

By the same reasoning, Congress can convert a cooperative federal-state spending program into a solely federal spending program. For example, in 1972, Congress nationalized what had previously been federal-state cooperative cash assistance programs for the aged, blind, and disabled by establishing the Supplemental Security Income ("SSI") program. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 38 (1981). That Congress can make such a change reflects the basic principle that the States do not gain a "vested" or otherwise constitutionally protected interest in the continuation of a federal-state cooperative spending program after Congress determines that continued federal subsidization of such a program is no longer its preferred course.[14]

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[13] The "breadth" of Congress' spending power "was made clear in *United States v. Butler*, 297 U. S. 1, 66 (1936), where the Court . . . determined that 'the power of Congress to authorize expenditure of public moneys for public purposes is not limited by the direct grants of legislative power found in the Constitution.'" *Dole*, 483 U.S. at 207.

By choosing to structure Medicaid as a scheme of "cooperative federalism," Congress allows for *more* state control and flexibility than would be available under a fully national program. It would be highly counterintuitive, to say the least, for Congress' choice to proceed in this fashion to somehow require that Congress limit the scope, effectiveness, or beneficial nature of its efforts, so as to avoid creating a program that is "too large," "too beneficial," or "too popular" for the States to decline. The States, as sovereign entities, must have the legal ability to decline to participate if they choose. But States have no constitutional interests in limiting the degree to which joint state-federal spending programs can meet the serious national needs of the populace. Our system of federalism does not protect state sovereignty by seeking to limit the effectiveness of otherwise proper federal actions.

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[14] This Federal right to change course can certainly be no surprise to the States here, since it has been made explicit within the Medicaid program itself. Since Medicaid was first created, its underlying statute has explicitly stated that Congress could at any time "alter, amend, or repeal" any aspects of the program, including the eligibility rules, on a going forward basis. 49 Stat. 648 (1935), *codified at* 42 U.S.C. §1304. Of course, Congress' "right" to amend the Medicaid program stems from the Constitution itself, not from this express "reservation" via statute.

In any case, little would be accomplished with regard to safeguarding state prerogatives by adopting the peculiar approach advocated by Petitioners here. If Congress cannot expand Medicaid simply because it is too big, too successful, and too generous to the States, that would incentivize Congress to adopt a fully national program, as it did with SSI. That would deprive the States of the control and flexibility over the program that they currently maintain, and that they will continue to maintain after the expansion (and deny the citizenry of the advantages that such flexibility represents). An appropriate respect for the values of federalism would discourage, not promote, such a result.

2. Given the arguments above, it should be no surprise that Petitioners find no support for their challenge to the size of expanded Medicaid in this Court's prior Spending Clause cases. To the contrary, the Court has long rejected challenges to federal funding conditions that simply delineate the scope of programs that Congress is willing to support.

For example, in *Massachusetts v. Mellon*, 262 U.S. 447 (1923), the Court rejected a State's challenge to the federal Maternity Act, which appropriated funds to States that adopted programs complying with its provisions designed "to reduce maternal and infant mortality and protect the health of mothers and infants." *Id.* at 479. The Court did not suggest that the amount of federal funding was relevant, holding instead that Massachusetts' suit "present[ed] no justiciable controversy, either in its own behalf or as the representative of its citizens," because "the powers of the state [we]re not invaded, since the statute impose[d] no obligation but simply extend[ed] an option which the state [wa]s free to accept or reject." *Id.* at 480.

Similarly, in *Lau v. Nichols*, 414 U.S. 563 (1974), the Court rejected a challenge to Title VI of the Civil Rights Act of 1964, which conditions *all* federal funding to a given state agency or department on a prohibition on discrimination based on race, ethnicity, or national origin within that state entity. The Court based its decision on the basic proposition that "the Federal Government has power to fix the terms on which its money allotments to the States shall be disbursed." *Id.* at 569. The Court also relied on *Oklahoma v. United States Civil Service Commission*, 330 U.S. 127 (1947), where the Court upheld a Hatch Act requirement prohibiting state and local officials in agencies subsidized by federal funds from "tak[ing] any active part in political management or in political campaigns." *Id.* at 129 n.1 (internal quotation marks omitted). Together, *Lau* and *Oklahoma* reflect this Court's consistent view that, at least where Congress has done nothing more than direct that federal funds not be expended for purposes it does not support, the alleged "coercive effect" of withholding otherwise allocated federal moneys is not an "interference with the reserved powers of the state." *Oklahoma*, 330 U.S. at 142-43; *see Lau*, 414 U.S. at 569.

The only case in which this Court suggested that the amount of federal funding put into jeopardy by a condition might be relevant to a challenge of that condition was *Dole*, 483 U.S. at 211. And, as previously explained (pp. 8-12, *supra*), the condition at issue there, unlike the conditions at issue here, fell outside the scope of the federal spending program itself. *Cf. Rust*, 500 U.S. at 196-97.

Finally, since *Dole*, the Court has not hesitated to enforce conditions on state participation in a federal spending program where those conditions would otherwise be within federal power, even if, by the Court's own acknowledgment, rejecting the federal funds would be "unrealistic." *Board of Educ. of Westside Cmty. Schs. v. Mergens*, 496 U.S. 226, 241 (1990).[16] There is simply no independent constitutional principle that the States must remain free of

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[16] In *Mergens*, the Court rejected a First Amendment challenge to the Equal Access Act, which prohibits public secondary schools that receive federal financial assistance and that "permit[] one or more 'noncurriculum related student groups' to meet on campus before or after classes" from denying "'equal access'" to campus facilities to other student groups, including religious groups. 496 U.S. at 233, 237 (quoting 20 U.S.C. §4071(a)-(b)). In the course of interpreting the Act in a manner that gave it broad application, the Court explained that "a school district seeking to escape the statute's obligations could simply forgo federal funding." *Id.* at 241. The Court

(continued)

having to make hard political choices in determining whether to participate in a federal spending program that is otherwise clearly within Congress' authority to offer.

3. As we have shown, the arguments offered by Petitioners are rooted in neither the structure of the Constitution nor in the precedents of this Court. But they should fail for another reason as well. Petitioners essentially argue that States face tremendous political pressures from their own residents to provide similar benefits to those in pre-expansion Medicaid, but would face difficulties in doing so absent federal funds because increasing local taxes would be politically intolerable. Judging these assertions in any meaningful way, if they were deemed legally relevant, would enmesh the judiciary in evaluating the relative strengths of various local political pressures and the relative merits of possible political tradeoffs. But evaluating such purely political forces and policy options is not a normal judicial function. "[T]he Justices of this Court lack both the expertise and the familiarity with local problems so necessary to the making of wise decisions with respect to the raising and disposition of public revenues." *San*

(continued)

"d[id] not doubt that in some cases this may be an *unrealistic* option," *id.* (emphasis added), but the Court did not even suggest that the possible practical infeasibility of rejecting federal funding might raise any substantial constitutional questions. Rather, the Court explained that the obligation to adhere to the Equal Access Act's provisions was simply "the price a federally funded school must pay if it opens its facilities to noncurriculum-related student groups." *Id.*

Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 41 (1973).

Accepting Petitioners' arguments would also inevitably thrust the judiciary into a realm of quintessentially political decision-making regarding the relative importance and inter-relationship of different aspects of a federal spending program that Congress has linked together as necessary to promote the general welfare. Petitioners demand access to "preexisting" federal funds (Pet. Br. 40) to support smaller, previously funded programs that Congress is no longer willing to support in such form. It would be beyond the proper judicial role (and judicial expertise) for the courts to determine when a program that Congress has chosen to finance only if operated in an integrated fashion must instead be separated into smaller parts, with Congress required to fund certain parts separately over its express objection. This Court has long recognized that, "[i]n determining essentials" of the programs it is willing to subsidize, "Congress must have the benefit of a fair margin of discretion." *Steward Machine*, 301 U.S. at 594. Judicial disagreement about the "fundamental quality of one or more of the conditions . . . will not avail to vitiate [a] statute" unless "the basic standards" Congress has adopted are no more than arbitrary. *Id.*

Congress here made a reasonable judgment that to most effectively promote the general welfare it is willing to fund only an integrated Medicaid program that takes a sufficiently broad approach to the issue of healthcare coverage for low-income individuals. Congress enacted the Medicaid expansion as part of comprehensive legislation designed to address the national healthcare crisis, including the gap in coverage that left some 50 million people uninsured in 2009. U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, Tbl. 8, at 23 (2010).[16] Congress concluded that its prior, smaller scale Medicaid program failed to address that problem adequately. It determined that continuing federal funding to programs in individual States that limited themselves to such smaller scale would not promote the comprehensive healthcare approach that Congress sought to achieve. The Court should reject Petitioners' invitation to enmesh the judiciary in the political and policy-driven debates about the wisdom of Congress' judgment.

4. In the end, although Petitioners deny that they are asserting a "vested" right under the Constitution to the continued benefits of a now superseded federal spending program (Pet. Br. 41), that really is the essence of what they contend. In effect, they assert that the States have become so "dependen[t]" on Medicaid funding that Congress may no longer make material changes to the program, such as might condition continued receipt of old-program benefits on any new requirements. Pet. 40-42. Petitioners seem to argue that once Congress has created this "dependency," it loses its discretion to make any such alterations in the program that the States have come to enjoy.

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[16] *See* U.S. Minimum Coverage Br. 9-12 (discussing framework of incentives and regulations established by the ACA designed to reform health insurance markets and expand access to healthcare services).

Accepting this novel argument not only would treat the States in a manner highly inconsistent with the constitutional plan — i.e., treat them as dependent entities in need of forced federal assistance, secured by judicial intervention — but it also would mean that Congress' authority to define the scope of the programs it is willing to fund is limited by either the States' present desires or the spending decisions of prior Congresses. It is settled law that Congress' power cannot be so constrained.

Nothing could be clearer than that "a State cannot compel use of federal property [or funds] on terms other than those prescribed or authorized by Congress. . . . Article VI of the Constitution, of course, forbids state encroachment on the supremacy of federal legislative action." *Ivanhoe Irrigation Dist. v. McCracken*, 357 U.S. 275, 295 (1958); *see Helvering*, 301 U.S. at 645 ("When money is spent to promote the general welfare, the concept of welfare or the opposite is shaped by Congress, not the states."); *Florida Prepaid*, 527 U.S. at 686-87.[17]

This bedrock principle flows not only from the Supremacy Clause, but from the Appropriations Clause, as well. U.S. Const. Art. I, §9, cl. 7; *see Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414, 428 (1990) (Appropriations Clause serves to "assure that public funds will be spent according to the letter of the difficult judgments reached by Congress as to the common good"). "'However much money may be in the Treasury at any one time, not a dollar of it can be used in the payment of anything not . . . previously sanctioned [by Congress.]'" *Id.* at 425 (quoting *Reeside v. Walker*, 52 U.S. 272, 291 (1850)); *accord Cincinnati Soap Co. v. United States*, 301 U.S. 308, 321 (1937); *Knote v. United States*, 95 U.S. 149, 154 (1877). To the extent they seek continued access to federal funds to support programs of a size that Congress has decided no longer to subsidize, Petitioners seek this Court's assistance to compel a result expressly forbidden by these constitutional commands.

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[17] *See also Buckley v. Valeo*, 424 U.S. 1, 90 (1976) (per curiam); *Dole*, 483 U.S. at 207.

Moreover, Congress' authority to define the scope of the programs it is willing to support cannot constitutionally be limited by the fact that past Congresses supported certain programs that have become large and popular. "'One legislature . . . cannot abridge the powers of a succeeding legislature.'" *Lockhart v. United States*, 546 U.S. 142, 147 (2005) (Scalia, J., concurring) (quoting *Fletcher v. Peck*, 6 Cranch 87, 135 (1810)); *see also Marbury v. Madison*, 1 Cranch 137, 177 (1803) (a statute is "alterable when the legislature shall please to alter it"). This Court's cases "have uniformly endorsed this principle." *Lockhart*, 546 U.S. at 147 (Scalia, J., concurring) (citing cases).

Congress could terminate the Medicaid program entirely. And Congress could subsequently create a new program identical to the one established by the Medicaid expansion at issue here. That is, in practical effect, exactly what Congress has done here. Petitioners' complaint about Congress' decision to tie the present Medicaid expansion to "pre-existing" funding (Pet. Br. 40) therefore is not of constitutional moment, because Petitioners have no right to that "pre-existing" funding.[18]

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[18] Petitioners seek to bolster their supposed "right" to continue under an unamended Medicaid program by complaining that residents in a State that opted out of Medicaid would continue to pay general federal taxes, but obtain lesser benefits than those in States that had not opted out. Pet. Br. 43-44. They add that this level of federal tax burden would make it more difficult for such a State to finance a comparable state healthcare program free of the federal requirements. *Id.* at 44-45. Indeed, they analogize the federal tax burden that corresponds to federal Medicaid costs to the work of a "pickpocket who takes a wallet and gives the true owner the 'option' of agreeing to certain conditions to get it back or having it given to a stranger." *Id.* at 44. But this inflammatory characterization adds nothing of constitutional relevance. Such a complaint could apply to *every* conditional federal funding program, regardless of size, and does not comport with basic constitutional principles. *See, e.g.*, *Steward Machine*, 301 U.S. at 589-90. When the federal government imposes taxes on individuals, it is taxing them as residents of the United States of America, not as residents of any particular State. Federal taxes therefore do not take for federal use anything to which the States have some entitlement. That is why this Court has long held that when a federal tax "has the effect of removing property [or funds] from [a State's] reach which otherwise would be within it, that is a contingency which affords no ground for judicial relief." *Florida v. Mellon*, 273 U.S. 12, 17 (1927).

Similarly, when the federal government appropriates money from the federal Treasury, it has no obligation to allocate those funds among the States in direct proportion to taxation revenues from the residents of the States. Indeed, "[t]his

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* * *

Congress, in enacting the Medicaid expansion in question, has done nothing more than expand the scope of an existing federal program. In doing so, Congress acted well within the core of its powers. Petitioners have offered no coherent, constitutionally justified, or judicially manageable principle suggesting otherwise.

If States disagree with the wisdom of Congress' spending choices, they may use their substantial political influence to convince Congress to take a different approach. Nothing prevents the States from joining together to persuade Congress that its view of the general welfare is mistaken, or from collectively exerting pressures on Congress to enact changes. If Congress' conception of the general welfare is at odds with the popular conception, the political process gives the States ample power to influence Congress to adopt a different course.

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Court has repudiated the suggestion, whenever made, that the Constitution requires the benefits derived from the expenditure of public moneys to be apportioned to the burdens of the taxpayer . . . ." *Carmichael v. Southern Coal & Coke Co.*, 301 U.S. 495, 522-23 (1937) (citing cases). Contrary to Petitioners' implicit – and radical – argument, it is well-established that "[a] tax is not an assessment of benefits." *Id.* Rather, it is "a means of distributing the burden of the cost of government," and "[t]he only benefit to which the taxpayer is constitutionally entitled is that derived from his enjoyment of the privileges of living in an organized society, established and safeguarded by the devotion of taxes to public purposes." *Id.*

CONCLUSION

The judgment below upholding the Medicaid expansion should be affirmed.

Respectfully submitted,

STEPHEN P. BERZON
Counsel of Record
SCOTT A. KRONLAND
MATTHEW J. MURRAY
Altshuler Berzon LLP
177 Post Street, Suite 300
San Francisco, CA 94108

JUDITH A. SCOTT
WALTER KAMIAT
MARK SCHNEIDER
Service Employees
International Union
1800 Massachusetts
Avenue, N.W.
Washington, D.C. 20036

PATRICK J. SZYMANSKI
Change to Win
1900 L Street, N.W.,
Suite 900
Washington, D.C. 20036

February 17, 2012

AMICUS CURIAE BRIEF

No. 11-400

In The
Supreme Court of the United States

FLORIDA, ET AL.,
Petitioners,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

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BRIEF *AMICI CURIAE* OF STATE LEGISLATORS FROM THE FIFTY STATES, THE DISTRICT OF COLUMBIA, AND PUERTO RICO SUPPORTING RESPONDENTS
(Medicaid)

DOUGLAS T. KENDALL
ELIZABETH B. WYDRA*
*Counsel of Record
CONSTITUTIONAL ACCOUNTABILITY CENTER
1200 18th St., NW, Ste 1002
Washington, D.C. 20036
(202) 296-6889
elizabeth@theusconstitution.org

Counsel for Amici Curiae

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INTEREST OF *AMICI CURIAE*

Amici Curiae, a group of 539 State Legislators from all 50 States, the District of Columbia and Puerto Rico, believe that the Patient Protection and Affordable Care Act ("the Act" or "ACA") is constitutional and are working hard in their States to implement the Act in a timely, efficient, and effective manner. They have a substantial interest in having this matter resolved expeditiously and in favor of the constitutionality of the Act. A full list of *Amici* State Legislators is contained in the Appendix.

Amici State Legislators include legislators from every single one of the States represented by the Act's challengers. These legislators have a particular interest in this case in order to represent their constituents and many other residents and State leaders in the challengers' respective States who disagree with these legal challenges and support health care reform. All of the *Amici* State Legislators have an interest in presenting their view of the respective powers of the federal and State governments, and whether the ACA's Medicaid expansion "coerces" the States.[1]

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae* or their counsel made a monetary contribution to its preparation or submission. Pursuant to Supreme Court Rule 37.3, *amici curiae* state that all parties have consented to

INTRODUCTION AND SUMMARY OF ARGUMENT

Petitioner States and elected officials claim that Congress's expansion of Medicaid in the Patient Protection and Affordable Care Act to include additional working poor and other low-income Americans violates constitutional principles of federalism. Their argument has little to do with the Constitution, and far more to do with a desire to obtain a judicial "do-over" on the Affordable Care Act, trying to get this Court to craft a health care reform law that is more to the Petitioners' liking. *See, e.g.*, JA 21-22 (docket entry # 80, Pls.' Mem. in Support of Summary Judgment 26 (praising the Medicaid program of the 1960s and 1970s as "the hallmark of cooperative federalism" but objecting to the "new" Medicaid standards)). That is an effort that belongs in the political arena, not in the courts.

At any rate, Petitioners' claim that the Act's Medicaid expansion is unconstitutionally "coercive" is fundamentally flawed in light of the fact that the States continue to have the choice to opt out of Medicaid and its various requirements altogether. Unsurprisingly, Petitioners are reluctant to end their participation in the federal-State Medicaid program, because to do so "would desert millions of their residents, leaving them without access to the healthcare services they have depended on for decades under Medicaid." JA 57 (Second Amended Complaint ¶ 66). This is absolutely true—Americans, including the

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the filing of this brief; blanket letters of consent have been filed with the Clerk of the Court.

most vulnerable among us, have come to appreciate and rely upon Medicaid. But the Constitution allows the federal government to structure or condition federal funds and programs in a certain way, allowing States to choose whether to participate and accept those conditions, or not. It is well-established that "Congress may attach conditions on the receipt of federal funds." *South Dakota v. Dole*, 483 U.S. 203, 206 (1987). State leaders must now choose whether to comply with the new Medicaid requirements, or exercise their right to opt out of the program altogether. Petitioners cannot expect the Court to absolve them of this choice by picking and choosing among parts of the federal Medicaid program. This choice may be "politically painful," but it is not "unconstitutionally 'coercive.'" *Jim C. v. United States*, 235 F.3d 1079, 1082 (8th Cir. 2000).

Petitioners link coercion concerns stemming from this Court's Spending Clause doctrine to the "anti-commandeering" principles articulated by the Court to protect our federalist system. This Court has never expressly joined these separate doctrinal spheres, and it should decline Petitioners' invitation to do so here. But even under Petitioners' doctrinal amalgamation, the federalism concerns articulated in the relevant cases—voluntariness, political accountability, and resources—all cut against their arguments. With respect to voluntariness, the States are and always have been able to withdraw from the Medicaid program, although *Amici* State Legislators think that would be an unwise and unpopular policy choice. With respect to resources, the ACA's Medicaid expansion could hardly be further from an "unfunded mandate"—in fact, Petitioners appear to argue that the ACA offers *too* generous a deal to the States. Finally, with respect to accountability, it is the Petitioners' argument that threatens the Constitution's careful balance of governmental power by asking the Court to do what they cannot or will not do through the legislative and political processes for fear of the political consequences. Despite Petitioners' contention that upholding the ACA's Medicaid expansion will wreak irreparable "structural damage to our constitutional system," Petr. Br. at 59, it is the string of entirely novel doctrinal limitations Petitioners assert—on everything from Congress's power to tax, to appropriate funds, and to control policy details, not to mention the denigration of State autonomy suggested by the Petitioners' apparently dim view of State officials' ability to represent their constituents—that poses the danger to our Constitution.

While Petitioners claim to represent the people of their respective States and the interests of the States in general, the State legislators appearing herein as *amici*—from every State in the Union, Puerto Rico, and the District of Columbia—do not agree with Petitioners' claim of "coercion." Health care reform was imperative for Americans, as well as for their State and local governments. The ever-rising costs of and limited access to insurance coverage and health care have severely stressed the budgets of State governments and American families; expanding Medicaid is perhaps the most significant way to extend access to quality, affordable health care. The Affordable Care Act's Medicaid expansion is within Congress's constitutional powers and is fully consonant with our federalist system.

ARGUMENT

I. The Affordable Care Act Respects The Federal-State Partnership On Health Care And Preserves Constitutional Federalism.

Our Constitution establishes a vibrant system of federalism, with "dual sovereignty between the States and the Federal Government." *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991). As the Court has recognized, "this federalist structure of joint sovereigns preserves to the people numerous advantages," including "a decentralized government that will be more sensitive to the diverse needs of a heterogenous society," enhanced "opportunity for citizen involvement in democratic processes," and "more innovation and experimentation in government." *Id.* at 458.

Performing their role as "laboratories of democracy," States historically have been leaders in policy innovations that better protect their citizens, resources, and environment. *See* Exec. Order on Federalism No. 13132, 64 Fed. Reg. 43255, § 2(e) (Aug. 4, 1999) ("States possess unique authorities, qualities, and abilities to meet the needs of the people and should function as laboratories of democracy.") In particular, the States have a long history of leadership on health care reform—indeed, the Patient Protection and Affordable Care Act incorporated the valuable lessons learned from the experience of health care reform practices by our State and local governments.

The Medicaid Act, enacted in 1965 in Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, took advantage of the States' longstanding role in providing for the health and welfare of their citizens by establishing a federal-State partnership. Medicaid is "a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). It is, and always has been, a voluntary program for the States. *Id.* "States are not required to participate in Medicaid, but all of them do." *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006).

Medicaid enables States to receive a significant amount of federal aid in exchange for the States' establishing public health insurance programs for the poor, subject to minimum federal requirements, *e.g.*, 42 U.S.C. § 1396(a)(10)(A)(I) (requiring the States to extend medical coverage to "categorically needy" individuals). "Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of the [Medicaid Act]." *Harris v. McRae*, 448 U.S. 297, 301 (1980). *See also Frew v. Hawkins*, 540 U.S. 431, 433 (2004); *Atkins v. Rivera*, 477 U.S. 154, 156-57 (1986). Congress expressly reserved the "right to alter, amend, or repeal any provision" of Medicaid, 42 U.S.C. § 1304, and has done so many times. *E.g.*, Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) (requiring participating States to extend Medicaid to recipients of Supplemental Security Income); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103

Stat. 2106 (1989) (requiring States to expand Medicaid coverage to pregnant women and to children under six years old, subject to certain income limits). *See* U.S. Br. (Medicaid) at 5-7. In addition to complying with coverage requirements, States must also comply with certain administrative requirements, *e.g.*, 42 U.S.C. §§ 1396a(a)(7), (9), (69), and federal civil rights laws, *e.g.*, 45 C.F.R. Pt. 80, 84. *See* U.S. Br. (Medicaid) at 3-4.

Again, States do not have to participate in Medicaid at all; in fact, Arizona did not join Medicaid until 1982. *See* Management of Arizona Medicaid Waiver: Hearings before the Subcomm. on Health & the Environment of the House Comm. on Energy & Commerce, 98th Cong., 2d Sess. 222 (1984). However, Medicaid is an undeniably attractive partnership because it covers a broad array of services and supports that aim to meet the needs of low-income people (especially children and people with disabilities), who are more likely than people with higher incomes to be in fair or poor health. JANUARY ANGELES & MATTHEW BROADUS, FEDERAL GOVERNMENT WILL PICK UP NEARLY ALL COSTS OF HEALTH REFORM'S MEDICAID EXPANSION 2 (Center on Budget and Policy Priorities, April 20, 2010). Moreover, after adjusting for the health status of recipients, Medicaid is significantly less costly, on a per-beneficiary basis, than private insurance, largely due to its lower provider rates and administrative costs. *Id.*

Like the previous Medicaid expansions undertaken since the program began in 1965—which required States to cover infants, children, pregnant women, and the disabled, *inter alia*—the Affordable

Care Act requires participating States to cover an additional category of needy individuals. Specifically, the ACA extends Medicaid eligibility to certain individuals under 65, not receiving Medicare, and with incomes up to 133% of the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VII). As the United States has made clear, these "eligibility standards *define* the Medicaid program, going to the very core of the offer of federal financial assistance that Congress has extended to the States and specifying how the federal dollars will be spent." U.S. Br. (Medicaid) at 24. Beyond these minimum coverage requirements, States have the option of including additional categories of Medicaid recipients, generally at the same rate of federal reimbursement, which, prior to the ACA, was between 50% and 83%, depending on a State's *per capita* income. Every single State has opted to extend eligibility in some manner and to provide some optional benefits. Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options*, App. B, Tbl. 1, at 4 (Jan. 2012). This allows for the diversity and innovation that is the hallmark of the States. *See generally New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (observing that, under our federalism, "a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country"). In fact, in some States—Maine, for example—this optional expanded coverage, undertaken prior to the ACA, remains broader than the eligibility expansion contained in the Act. The ACA's expansion of Medicaid thus reflects State experience and policy preferences, and is hardly the unreasonable expansion Petitioners suggest (let alone an unconstitutional one).

Far from being a burden on the States, the ACA's Medicaid expansion will allow millions more Americans access to quality, affordable health care while minimizing the strain on State and local government budgets. The government will pay 100% of the costs of providing medical assistance to the expanded coverage group from 2014 to 2016, gradually decreasing the support to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter. 42 U.S.C. § 1396d(y). *See also* ANGELES & BROADUS, at 3. Largely as a result of this increased federal spending, the States will only slightly increase their Medicaid spending in the next decade, while covering substantially more of their citizens. This slight increase has been pegged at approximately 0.8% above what States were projected to spend by the Congressional Budget Office, although Petitioners cite to another study that suggests an approximate 1.75% increase. *Compare* U.S. Br. (Medicaid) at 10 (citing CONG. BUDGET OFFICE, SPENDING & ENROLLMENT DETAIL FOR CBO'S MARCH 2009 BASELINE: MEDICAID (2009)) *with* Petr. Br. at 10 (citing Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Coverage & Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* (May 2010)). Using these different projections, States will increase their Medicaid spending by approximately $20 billion to $43.2 billion—a mere fraction of the $1.6 trillion that States were projected to spend on Medicaid, for fewer people, over the same time frame, in the absence of health care reform. ANGELES & BROADUS, at 4. At the same time, the Congressional

Budget Office estimates that the Medicaid changes will result in $434 billion in extra federal Medicaid and Children's Health Insurance Program money flowing to the States between 2010 and 2019. Expanding health care coverage will also substantially lower the cost to States for uncompensated care. *See* Council of Economic Advisors, *The Impact of Health Insurance Reform on State and Local Governments* (Sept. 15, 2009).[2]

The benefits of national health care reform for States and their citizens will be substantial, in part because the size of the problem with health care is so great. Despite the fact that Americans spent an estimated 2.5 trillion dollars on health care in 2009, more than 45 million Americans do not have health insurance. Pub. L. No. 111-148, §§ 1501(a)(2)(B),

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[2] There are additional benefits and costs recovered in the long-term, which include having a more robust and healthy workforce and better quality of care overall. When communities have a large uninsured population, even insured people will have decreased access to adequate health care. Institute of Medicine, AMERICA'S UNINSURED CRISIS 108-09. States will also be better positioned to attract and maintain hospitals. Medical research facilities may increase the attention paid to diseases and health problems affecting traditionally uninsured populations, because health insurance would assure financial return. In addition, health care will become less costly for the insured, affording those families greater spending power. *See* Carole Keeton Strayhorn (Texas Comptroller of Public Account), *The Uninsured: A Hidden Burden on Texas Employers and Communities*, Apr. 2005.

10106(a), 124 Stat. 119, 907 (2010); *see also* CONG. BUDGET OFFICE, 2008 KEY ISSUES IN ANALYZING MAJOR HEALTH PROPOSALS 11 (Dec. 2008); CONG. BUDGET OFFICE, THE LONG-TERM BUDGET OUTLOOK 21-22 (June 2009). Individuals and families face disastrous personal and financial consequences when they find themselves with serious medical problems and no insurance. *See* Pub. L. No. 111-148, §§ 1501(a)(2)(G), 10106(a) (noting that 62% of all personal bankruptcies are precipitated in part by medical expenses); Institute of Medicine, AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 58, 78-79, 80 (2009) (observing that uninsured people have a higher likelihood of being hospitalized and of dying prematurely, and of experiencing greater limitations on their quality of life when compared to insured people). In addition, when the uninsured receive medical assistance, the uncompensated health care costs, which were $43 bilbillion in 2008 alone, are borne by federal, State and local governments, as well as by those who pay for insurance and health care providers. Pub. L. No. 111-148, §§ 1501(a)(2)(F), 10106(a).

The Act will help address these serious problems by reducing the number of uninsured Americans by approximately 32 million in the next decade, and lowering the average insurance premium paid by individuals and families in the individual and small-group markets. Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to the Hon. Nancy Pelosi, Speaker, U.S. House of Representatives 9 (March 20, 2010); CONG. BUDGET OFFICE, AN ANALYSIS OF HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

23-25 (Nov. 30, 2009). This substantial number of newly covered individuals is achieved in large part by the Act's requirement that the States expand Medicaid to all non-elderly individuals with incomes up to 133% of the poverty line, or about $29,000 for a family of four.

Amici State Legislators believe this represents a good deal for their constituents and their States. Petitioners appear to argue that this is *too* good a deal: one that they can't refuse. But it has been true for several decades, at least, that while "State participation in Medicaid is entirely voluntary, [] it is in a state's interest to participate since otherwise the state and its localities would, as a practical matter, have to provide many of the same services without the financial assistance of the federal government." Elizabeth Anderson, *Administering Health Care: Lessons from the Health Care Financing Administration's Waiver Policy-Making*, 10 J.L. & POL. 215, 220 (1994).

The federal-State partnership on health care that has already helped so many Americans through the Medicaid program is appropriately respected in the Affordable Care Act. The Act responds to a pressing, national health care crisis, while respecting the sovereignty and expertise of the States, reflecting the best of our federalism. The requirements of the Act and the funding it provides participating States will benefit both strained government budgets and the lives of each State's residents.

II. Petitioners' Coercion Claim and Novel Doctrinal Limitations Are Constitutionally Baseless And Threaten The Careful Balance Of Federal-State Power.

Petitioners allege that the Act's Medicaid-related provisions are unconstitutional because they amount to "coercion and commandeering," JA 65-66 (Second Am. Compl. ¶¶ 83-86), dramatically claiming that upholding the constitutionality of the Medicaid provisions would cause "structural damage to our constitutional system." Petr. Br. at 59. This claim fails at the outset because the States cannot be "coerced" into doing anything with respect to Medicaid—Medicaid is a voluntary federal-State partnership, which the States could opt out of if their leaders and citizens so desired, avoiding the Act's new requirements for expanded Medicaid coverage.

In an attempt to circumvent this basic truth, fatal to Petitioners' case, Petitioners declare the urgent need for this Court to place new limitations on Congress's power to tax and spend for the general welfare. But the Court has already recognized, in *South Dakota v. Dole*, the necessary limitations on Congress's Spending Clause power to preserve state sovereignty and our system of federalism. It is undisputed that the ACA's Medicaid expansion does not run afoul of those limits. Petitioners' attempt to invent additional limits that would allow them to remain in the Medicaid program, while avoiding the new requirements placed as a condition on the ACA's generous Medicaid funding grant, threatens to throw off-balance our Constitution's carefully calibrated balance of federal-State power. This Court should decline to allow Petitioners' desire to avoid political accountability for their policy preferences to distort our constitutional system of federalism.

A. Petitioners' Suggested Limits On Congress's Power To Tax And Spend For The General Welfare Are Unprecedented And Wrong-Headed.

As discussed in detail in *Amici* State Legislators' brief in support of the constitutionality of the minimum coverage provision, the federal system in the United States is founded on a Constitution that gives broad power to the federal government to act when a national solution is necessary or preferable, while preserving the role of State and local governments to create policies responsive to local needs and customs. *See* 2 MAX FARRAND ED., THE RECORDS OF THE FEDERAL CONVENTION OF 1787 (rev. ed. 1966), at 131-32 (reflecting that the delegates to the Constitutional Convention instructed the Committee of Detail, which drafted the enumerated powers of Congress in Article I, that Congress should have authority to "legislate in all Cases for the general Interests of the Union, and also in those Cases to which the States are separately incompetent"). *See generally* Federalist No. 2 (Jay), in THE FEDERALIST PAPERS (Clinton Rossiter ed., 1999); AKHIL REED AMAR, AMERICA'S CONSTITUTION: A BIOGRAPHY 108 (2005). Providing Congress the power to tax and spend was of central importance to the drafters of our Constitution: they had witnessed the disastrous consequences of the Articles of Confederation's failure to provide for such a power. Under the Articles, Congress had some powers, but was given no means to execute those powers.

Congress could not directly tax individuals or legislate upon them; it could raise money only by making requests to the States.

This created such an ineffectual central government that, according to George Washington, it nearly cost Americans victory in the Revolutionary War, and he lamented the dire situation in which the soldiers had been placed as a result of Congress's inability to levy taxes to support the Army. *See* 18 THE WRITINGS OF GEORGE WASHINGTON 453 (John C. Fitzpatrick, ed. 1931) (Letter to Joseph Jones, May 31, 1780). *See also* WASHINGTON: WRITINGS 393 (John Rhodehamel, ed. 1997) (Circular to State Governments, Oct. 18, 1780); *id.* at 502-503 (Letter to Lund Washington, March 19, 1783). Washington believed that the inability of the central government to address common concerns such as the maintenance of an army could bring disaster: "The sufferings of a complaining army, on the one hand, and the inability of Congress and tardiness of the States on the other, are the forebodings of evil." *Id.* at 488 (Letter to Alexander Hamilton, March 4, 1783).

This historical foundation explains why the Spending Clause is the first and one of the most sweeping powers the Constitution confers upon Congress, providing the power "to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States." U.S. CONST., art. I, § 8. The power to tax and spend for the common defense and general welfare is "an indispensible ingredient in every Constitution," THE FEDERALIST PAPERS NO. 30 (Hamilton), at 184, and it was essential for the Constitution to "embrace a provision for the support of the national civic list; for the payment of the national debts contracted, or that may be contracted; and, in general, for all those matters which will call for disbursements out of the national treasury." *Id.*

Even in 1936, in the midst of a period when the Court was actively limiting the authority of the New Deal Congress, this Court recognized the broad sweep of the Spending Clause's plain language. In *United States v. Butler*, 297 U.S. 1 (1936), this Court held that the "necessary implication from the terms of the grant is that the public funds may be appropriated 'to provide for the general welfare of the United States.'" *Id* at 65. Recognizing the Spending Clause as an independent grant of authority to Congress, the *Butler* Court held that "the power of Congress to authorize expenditure of public moneys for public purposes is not limited by the direct grants of legislative power found in the Constitution." *Id.* The Court was unanimous on this point. *Id.* at 80-81 (Stone, J. dissenting).

Nonetheless, Petitioners now ask this Court to place a myriad of new limitations on Congress's power to tax and spend, suggesting that these limits "are a necessary consequence of the federal government's successful effort to broaden the spending power," citing *Butler*. Petr. Br. at 28. These newfangled constitutional principles include:

- some sort of stricter coercion scrutiny "when Congress seeks to impose conditions on *entire blocks* of federal funding," Petr. Br. at 57;

- a limitation on Congress's power to spend treasury funds based on what the residents of each State pay in taxes, *e.g.*, Petr. Br. at 43-45;

- heightened scrutiny of spending legislation that touches on programs that have been popular with the States and in which the federal government's financial assistance is "massive," Petr. Br. at 58; and

- a presumption of unconstitutionality when Congress assumes the continued participation of States in a program that they have participated in for decades, and where Congress is offering to pay for the vast majority of the new aspects of the program, *e.g.*, Petr. Br. at 39-42.

None of these proposed limitations is supported by the Constitution or precedent—nor is Petitioners' suggestion that *Butler* somehow "broadened" Congress's power to tax and spend. Petr. Br. at 28. In fact, the *Butler* Court simply, and, without any dissent on this point, decided the "true construction" of the Constitution's text. *Butler,* 297 U.S. at 66.

Petitioners' effort to impose new limitations on Congress's expressly delegated powers should be rebuffed, in order to preserve the constitutional balance of power that has proved adequate to the task of governing a nation and preserving individual liberty through the "double security" of strong federal and State governments. THE FEDERALIST PAPERS NO. 51 (Madison), at 320. As discussed below, the Court's Spending Clause doctrine already contains the necessary safeguards to ensure that States are not unconstitutionally coerced by Congress's conditioned spending. Petitioners' inability to make out a case of coercion under existing doctrine is hardly a reason to invent new constitutional rules.

B. Petitioners' Desire To Avoid The Political Consequences Of Opting Out Of The Valuable And Popular Medicaid Program Does Not Amount To Unconstitutional Coercion or Commandeering.

Recognizing that Medicaid is a valued program that provides crucial access to care for millions of the Petitioners' constituents, Petitioners attempt a novel argument—merging the Court's coercion and anti-commandeering doctrines—that tries to keep what they like about the program, including substantial federal funding, while avoiding the Act's new requirements, which they oppose. *See* JA 57 (Second Am. Compl. ¶ 65). This argument presents neither a claim of coercion nor of commandeering and should be denied.

This Court has made clear that the temptation to accept federal funds does not amount to coercion. *South Dakota v. Dole*, 483 U.S. 203, 212 (1987). The Constitution allows the federal government to structure or condition federal funds and programs in a certain way, allowing States to choose whether to participate and accept those conditions, or not. It is well-established that "Congress may attach conditions on the receipt of federal funds." *Id.* at 206. When the Court validated the Social Security Act, for example, it recognized that to hold that "motive or temptation [on the part of a State to comply with a condition attached to a federal appropriation grant] is equivalent to coercion is to plunge the law in endless difficulty." *Steward Machine Co. v. Davis*, 301 U.S. 548, 589-90 (1937).

Congress's spending power enables it to condition the disbursement of federal funds on States' meeting particular criteria. This extends to conditions that require States to fund programs or otherwise spend state funds for particular purposes. *See King v. Smith*, 392 U.S. 309 (1968) (upholding statute that conditioned federal matching funds on certain State actions, including the expenditure of State funds, because, if Alabama wanted to continue receiving the federal funds, it had to abide by the conditions). If the State finds the conditions too onerous, it may simply refuse the federal funds. *See Oklahoma v. United States Civil Service Comm'n*, 330 U.S. 127 (1947) (upholding the Hatch Act, which required that any employee of a state highway commission [financed in whole or part with federal funds] must be removed from office if he/she was found to be engaging in political activities, because the federal government may attach conditions to disbursement of funds, and because the employee and the State have the right to refuse funds).

This may require elected State officials to face some difficult decisions, but "[i]n the tension between federal and state power lies the promise of liberty." *Gregory v. Ashcroft*, 501 U.S. 452, 459 (1991). The interplay between principles of federalism and Congress's Spending Clause authority leaves to "the residents of the State" the "ultimate decision whether or not the State will comply" with conditions placed on federal funds. *New York v. United States*, 505 U.S. 144, 166-67 (1992). "If a State's citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant." *Id.* at 168. The Petitioners do not really argue that they are truly *unable* to opt out of Medicaid if their constituents view the ACA's expanded coverage "as sufficiently contrary to local interests"—what they are arguing is that their constituents will be displeased if Petitioners opt out of Medicaid and their States are forced to severely cut benefits or significantly raise taxes. But that isn't coercion. It's simply a reflection of the fact that Petitioners' constituents probably do not "view federal policy as sufficiently contrary to local interests" that they would support declining the massive federal Medicaid grant and suffering the consequences. *Id.*

Similarly, the voluntary nature of Medicaid renders the Petitioners' "commandeering" claim regarding the Act's expansion of Medicaid coverage to over 16 million more low-income adults and children groundless. This Court has articulated an anti-commandeering doctrine that holds that the federal government "may not compel the States to enact or administer a federal regulatory program." *Printz v. United States*, 521 U.S. 898, 926 (1997); *New York*, 505 U.S. at 188. As a threshold matter, however, the Court has never joined its Spending Clause coercion jurisprudence directly to its "anti-commandeering" doctrine. Petitioners argue that "[i]f Congress were free to use its spending power to coerce States into enforcing the federal government's dictates, then the spending power would become the exception that swallows the anti-commandeering rule." Petr. Br. at 21. But this argument ignores a fundamental and categorical difference between federal mandates and federal spending conditions: the massive federal payments that make statutes like Medicaid work. This Court was appropriately concerned in *New York* and *Printz* about unfunded federal mandates that could divert and deplete state resources. It should be far less concerned about spending conditions that come with generous funding behind them.

Petitioners' argument also presupposes that the limits this Court has recognized with respect to Congress's spending power to prevent unconstitutional "coercion" are illusory, which they are not.

First, the text of the Constitution expressly limits Congress's spending power to the pursuit of "the general welfare." U.S. CONST. art. I, § 8; *Dole*, 483 U.S. at 207. Second, any conditions Congress places on grants to the States must be clear, thus "enable[ing] the States to exercise their choice knowingly, cognizant of the consequences of their participation." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Third, "conditions on federal grants might be illegitimate if they are unrelated 'to the federal interest in particular national projects or programs.'" *Dole*, 483 U.S. at 207 (citation omitted). Finally, "other constitutional provisions may provide an independent bar to the conditional grant of federal funds," *id.* at 208—Congress may "not 'induce' the recipient to 'engage in activities that would themselves be unconstitutional.'" *United States v. Am. Library Ass'n, Inc.*, 539 U.S. 194, 203

(2003) (plurality) (quoting *Dole*, 483 U.S. at 210). The United States acknowledges that Congress's Spending Clause power is limited by these principles, U.S. Br. (Medicaid) at 21-22, and these four principles define when "pressure turns into compulsion."[3]

But even accepting Petitioners' efforts to import a version of this Court's commandeering doctrine into Spending Clause doctrine, their arguments fail. Losing federally-funded Medicaid would surely be a bitter pill to swallow for Petitioners and their constituents, but Congress may constitutionally "hold out incentives to the states as a method of influencing a state's policy choices." *New York*, 505 U.S. at 166; *see also id.* at 167 ("Where the recipient of federal funds is a State, as is not unusual today, the conditions attached to the funds by Congress may influence a State's legislative choices."). So long as Congress merely "encourages state regulation rather than compelling it, state governments remain responsive to the local electorate's preferences; state officials remain accountable to the people." *Id.* at 168.

Indeed, while Petitioners dramatically suggest that opting out of Medicaid could have "severe consequences for poor Americans" similar to those that resulted from another "health-related event," Hurricane Katrina, JA 21-22 (docket entry # 80, Pls.' Mem. In Support of Summary Judgment at 36 n.34), other State leaders (even some who also represent States of the Petitioners) have expressed their view that rejecting the Affordable Care Act's Medicaid expansion would be in their State's best interest. For example, Texas Governor Rick Perry told a news outlet that opting out of the Medicaid program could save the state and federal government $40 billion each over six years: "We think in Texas over the next six years that we could take and find a private insurance solution and better serve our people, put more people under coverage." Althea Fung, *Texas Considers Opting Out of Medicaid*, NATIONAL JOURNAL, Nov. 15, 2010. *See also* Emily Ramshaw & Marilyn Serafini, *Battle Lines Drawn Over Medicaid in Texas*, N.Y. TIMES, Nov. 16, 2010 (noting that "the idea of dropping out of Medicaid is on the table in Texas and roughly a dozen other states, including Alabama, Mississippi, Washington and Wyoming"). This may not be a wise policy choice, but it is a *possible* choice—and one that demonstrates that States are not impermissibly "coerced" or "commandeered" into remaining in the Medicaid program.

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[3] Petitioners appear to view "anti-coercion" as an independent fifth limitation on the Spending Clause, but the *Dole* opinion does not support this view.

The decision State leaders face is clear: whether to take steps to implement the Act's expansion of Medicaid and work in partnership with the federal government to provide better health care for State residents, or to opt out of Medicaid altogether. Either of these choices is possible (although *Amici* State Legislators believe the first path is better for their States and their constituents). Accordingly, the political accountability concerns that animate the Supreme Court's anti-commandeering jurisprudence cut against Petitioners here. *Printz*, 521 U.S. at 929-30 (expressing the concern that, if Congress commandeered the machinery of the State, it could take credit for "solving" problems truly handled by the

State, or the States could be blamed for burdensome federal policies); *New York*, 505 U.S. at 168 (explaining that, by allowing Congress to encourage State regulation but not expressly compel it, officials are still accountable to the people for their choices). If the Court were to allow Petitioners to use its commandeering claims to, via judicial action, preserve the aspects of Medicaid they like—specifically, Medicaid prior to the passage of the Act, *see* JA 48 (Second Am. Compl. ¶¶ 39-41)—while doing away with the expanded coverage requirements of the duly enacted health reform law, the political accountability goals articulated in *New York* and *Printz* would be seriously undermined.

Congress established Medicaid in Title XIX of the Social Security Act of 1965; the States then had the option whether to jointly fund the program with the federal government, or not. Here, Congress has voted to expand Medicaid—as it expressly reserved the right to—to help reduce the number of uninsured people by 32 million over the next ten years; States can again determine whether to continue working with the federal government in the Medicaid partnership, or not. In either case, the elected federal officials and the elected State leaders will be accountable for their choices. The Petitioners seek to avoid that accountability by asking the Court to invalidate the new conditions placed on Medicaid funds while retaining the portions of the program they like. Such an argument does not properly raise a claim of unconstitutional "commandeering" or "coercion" and should be rejected.

CONCLUSION

Amici State Legislators support the steps toward effective health care reform undertaken in the Affordable Care Act and believe that the Act is fully constitutional. As State leaders who have taken an oath to be faithful to the U.S. Constitution and who are actively working to implement and prepare for various requirements of the Act, *Amici* respectfully urge the Court to uphold the constitutionality of the Affordable Care Act's expansion of Medicaid.

Respectfully submitted,

DOUGLAS T. KENDALL
ELIZABETH B. WYDRA*
**Counsel of Record*
CONSTITUTIONAL ACCOUNTABILITY CENTER
1200 18th St., NW, Suite 1002
Washington, D.C. 20036
(202) 296-6889
elizabeth@theusconstitution.org

Counsel for Amici Curiae State Legislators

February 17, 2012

APPENDIX

LIST OF *AMICI CURIAE* STATE LEGISLATORS

Abercrombie, Catherine, Assistant Majority Whip
Representative—Connecticut

Abinanti, Thomas J.
Assemblyperson—New York

Abrams, Stacey, Minority Leader
Representative—Georgia

Adams, Alma
Representative—North Carolina

Aguiar, James
Representative—New Hampshire

Albis, James
Representative—Connecticut

Alexander, Kelly
Representative—North Carolina

Alexander, Martha
Representative—North Carolina

Alfond, Justin, Assistant Senate Minority Leader
Senator—Maine

Allen, Alma
Representative—Texas

Almy, Susan
Representative—New Hampshire

Alonzo, Roberto
Representative—Texas

Alvarado, Carol
Representative—Texas

Anchia, Rafael
Representative—Texas

Antonio, Nickie
Representative—Ohio

Anzelc, Tom
Representative—Minnesota

Appleton, Sherry
Representative—Washington

Arce Ferrer, Luz
Senator—Puerto Rico

Aresimowicz, Joe, Deputy Speaker of the House
Representative—Connecticut

Armstrong, Joe
Representative—Tennessee

Arora, Sam
Delegate—Maryland

Ashe, Kathy
Representative—Georgia

Atkins, Bert
Representative—Missouri

Austin, Terri
Representative—Indiana

BaCote, Mamye
Delegate—Virginia

Baker, Glenn
Representative—Georgia

Bakk, Tom, Minority Leader
Senator—Minnesota

Barnett, Vicki
Representative—Michigan

Bartlett, Philip
Senator—Maine

Barve, Kumar, Majority Floor Leader
Delegate—Maryland

Bauer, Joan
Representative—Michigan

Beall, Daryl
Senator—Iowa

Beasley-Teague, Sharon
Representative—Georgia

Beavers, Roberta
Representative—Maine

Beck, Henry
Representative—Maine

Beliveau, Devin
Representative—Maine

Bell, Larry
Representative—North Carolina

Benedetto, Michael R.
Assemblyman—New York

Benn, Bernard
Representative—New Hampshire

Berry, Seth
Representative—Maine

Bobo, Elizabeth
Delegate—Maryland

Boland, Andrea
Representative—Maine

Bolkcom, Joe, Assistant Majority Leader
Senator—Iowa

Bordsen, Alice
Representative—North Carolina

Botzow, Bill
Representative—Vermont

Brannigan, Joe
Senator—Maine

Brennan, James
Assemblyperson—New York

Briggs, Sheryl
Representative—Maine

Brown, Charlie
Representative—Indiana

Brown, Michael
Representative—Missouri

Brown, Lisa, Majority Leader
Senator—Washington

Brown, Bonnie
Delegate—West Virginia

Bryant, Angela
Representative—North Carolina

Brynaert, Kathy
Representative—Minnesota

Buckner, Debbie, Minority Caucus Secretary
Representative—Georgia

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Burnam, Lon
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Butler, Larry
Representative—Connecticut

Butler, Gloria
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Senator—New Mexico

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Nos. 11-393 & 11-400

In The Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT
BUSINESS ET AL., *Petitioners*,
v.
KATHLEEN SEBELIUS ET AL., *Respondents*.

STATE OF FLORIDA ET AL., *Petitioners*,
v.
DEPARTMENT OF HEALTH & HUMAN SERVICES, ET AL.,
Respondents,

*On Writ of Certiorari to the United States
Court of Appeals for the Eleventh Circuit*

BRIEF OF JOELLA SWAN, DOROTHY GEPHART, UNITED MINE WORKERS OF AMERICA, NATIONAL COALITION OF BLACK LUNG AND RESPIRATORY DISEASE CLINICS, INC., and NATIONAL BLACK LUNG ASS'N AS AMICI CURIAE IN SUPPORT OF COURT-APPOINTED AMICUS ON SEVERABILITY

Grant Crandall
Arthur R. Traynor III
United Mine Workers
of America
Quantico Gateway Drive
Triangle, VA 22172
(703) 291-2400
gcrandall@umwa.org

Thomas E. Johnson*
Anne Megan Davis
Johnson, Jones,
Snelling, Gilbert 18354
& Davis, P.C.
36 S. Wabash Ave
Chicago, IL 60603
(312) 578-8100
tjohnson@jjsgd.com

*Counsel of Record
Attorneys for Amici Curiae

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STATEMENT OF INTEREST[1]

Joella Swan and **Dorothy Gephart** are both coal miners' widows. The late Harry Swan worked for more than 30 years in mines in Indiana, often at the coal face where the coal mine dust is most intense. The late Robert Lee Gephart was a miner for more than 20 years in Ohio and Indiana. These widows and their husbands were awarded "black lung" disability and survivor's benefits based upon Section 1556 of the Patient Protection and Affordable Care Act ("the ACA"), Pub. L. No. 111-148, §1556, 124 Stat. 119, 260 (2010), as amended by the Health Care and Education Reconciliation Act (Section 1556").

Section 1556 is a short and entirely independent section of the ACA that amended the Black Lung Benefits Act, 30 U.S.C. §§901-944 ("the BLBA"). The BLBA in turn governs a program of disability and survivor's benefits for persons who establish that they are totally disabled by coal workers' pneumoconiosis or other devastating chronic lung diseases arising out of coal mine employment (collectively referred to herein as "pneumoconiosis" or by the more colloquial term, "black lung disease").

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[1] No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. Petitioners and Respondents have filed with the Clerk of the Court letters granting blanket consent to the filing of *amicus* briefs.

Section 1556 reinstated two statutory provisions of the BLBA that had been eliminated in 1981 (discussed further below), both of which ease the burden of proving entitlement to black lung benefits for certain groups of claimants.

The **National Coalition of Black Lung and Respiratory Disease Clinics, Inc.** represents Black Lung Clinics Programs in 14 states where coal miners live and work. The Clinic Programs are dedicated to quality comprehensive care for victims of coal mine dust-induced lung diseases. In 2009, the Clinics offered medical services to 32,000 users in more than 110,000 medical encounters, and provided benefits counseling and community outreach in an additional 110,000 encounters.

The **National Black Lung Association** is an organization of miners, disabled miners, surviving spouses and other persons affected by coal mine dust-induced chronic lung diseases with 18 chapters across the nation. The Association helps miners and their families navigate the complicated process for filing and prosecuting claims for black lung benefits. The Association also advocates for changes in legislation and regulations to reduce the incidence of black lung disease and to improve the black lung benefits program.

The **United Mine Workers of America** ("the UMWA") is an international labor organization that represents active and retired coal miners in the United States and Canada. The UMWA was instrumental in securing passage of the Federal Coal Mine Health and Safety Act of 1969, Pub.L. 91-173, 83 Stat. 744 ("the 1969 Federal Coal Mine Act") which contained the earliest version of what is now known as the BLBA. For decades, the UMWA has participated in litigation in which coal mine operators and their insurers have argued unsuccessfully that various components of the BLBA's federal black lung compensation program violate the United States Constitution. *See, e.g., Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976) (UMWA filed brief as amicus curiae)*; National Mining Ass'n v. Chao,* 160 F.Supp.2d 47 (D.D.C. 2001) (UMWA intervened in defense of black lung regulations), *aff'd National Mining Ass'n v. U.S. Dept. of Labor*, 292 F.3d 439 (D.C. Cir. 2002); and *West Virginia CWP Fund v. Stacy,* __F.3d__, 2011 WL 6062116 (4th Cir., Dec. 21, 2011)(UMWA filed brief as amicus curiae). In addition, the UMWA has been involved for many years in efforts to improve workers' compensation programs in the coalfield states and to secure compensation benefits for its members. *See, e.g., United Mine Workers v. Illinois State Bar Ass'n*, 389 U.S. 217 (1967).

Coal workers' pneumoconiosis was a contributor or underlying cause of death for more than 73,800 United States miners from 1968 through

2005.[2] The amendments to the BLBA in Section 1556 are crucially important to coal miners with disabling black lung disease and their survivors. This is because claimants who seek black lung benefits under the BLBA and its accompanying regulations[3] must successfully prosecute their claims through a complicated matrix of legal requirements and adjudicatory proceedings, starting with an initial decision by the Office of Workers Compensation Programs within the U.S. Department of Labor ("the DOL"). This decision may be followed by a hearing before an administrative law judge within the DOL, then a series of appeals, first within the DOL to the Benefits Review Board, then to the U.S. Courts of Appeal and ultimately the U.S. Supreme Court. Black lung benefits, if finally awarded, are paid by the miner's employer or insurer; or, if the coal mine employer cannot be identified, by the Black Lung Disability Trust Fund ("the Trust Fund"), which is funded by an excise tax on coal producers.[4] Employers and the Trust Fund typically vigorously oppose these claims, which often turn on expert medical opinions. If successful, a claimant receives a modest monthly benefit (currently frozen at $625 for the miner),[5] as well as payments for the miner's respiratory medical care.[6]

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[2] U.S. Government Accountability Office, Report to the Chairman, Subcommittee on Health Care, Committee on Finance, U.S. Senate, *Black Lung Benefits Program: Administrative and Structural Changes Could Improve Miners' Ability to Pursue Claims*, GAO-10-7, p. 3, available at: http://www.gao.gov/newitems/d107.pdf (hereafter, "GAO Report"), citing figures extracted from the National Occupational Respiratory Mortality System, which is administered by the U.S. Department of Health and Human Services and available at http://webapp.cdc.gov/ords/norms.html.

[3] 20 C.F.R. Parts 718, 722, 725 and 726.

Between 1981, when the BLBA was last amended, and 2010, when Section 1556 became effective as part of the ACA, most black lung claims were denied. In 2008, 85% of the 4,416 claims considered were denied at the initial agency level alone. *GAO Report*, *supra* fn. 2, at 19. The majority of claimants take no action after the initial agency denial and thus forego their right to a hearing or subsequent review. *See GAO Report, supra* fn. 2, at 14. Miners' lack of financial resources to pay experts, the low probability of success, high litigation costs, long delays in adjudication, the statutory prohibition on settlement[7] and limitations on attorneys' fees[8] make it difficult for claimants to obtain legal representation. This further reduces the likelihood that benefits will be awarded. *See GAO Report, supra* fn. 2 at 26-27; *Lango v. Director, OWCP*, 104 F.3d 573, 575-76 (3d Cir. 1997).

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[4] 26 U.S.C. §§4121, 9501.

[5] *Black Lung Monthly Benefit Rates for 2011-2012*, Div'n of Coal Mine Workers' Compensation, U. S. Dept. of Labor. available at http://www.dol.gov/owcp/dcmwc/regs/compliance/blbene.htm.

[6] 20 C.F.R. §725, Subpart J. Medical benefits in the black lung program are governed solely by the BLBA and its implementing regulations, and are not based on any of the health care insurance provisions of the ACA.

Judge Posner has observed that adjudication of black lung claims is often "protracted scandalously," which is "especially regrettable because most black lung claimants are middle-aged or elderly and in poor health, and therefore quite likely to die before receiving benefits if their cases are spun out for years." *Amax Coal Co. v. Franklin*, 957 F.2d 355, 356 (7th Cir. 1992).

A decision that affirms the continued validity of Section 1556 is critically important to these amici. If the "minimum coverage" provision of the ACA, 26 U.S.C. §5000A, is declared unconstitutional but the Court does not apply the normal rule of severability, Section 1556 will fall with the rest of the ACA, and all awards of black lung benefits that have been made based on the amendments to the BLBA in Section 1556 will be subject to vacation. Mrs. Gephart, Mrs. Swan and other eligible claimants will have to go back to "square one" in hotly contested cases, but this time without the assistance of the less stringent requirements in Section 1556. This reversal will have a severe impact on ill and disabled miners and their surviving spouses, who struggle to assemble proof of entitlement against far-better financed opponents, and will in turn affect the miners' supporting organizations.

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[7] 30 U.S.C. §932(a).

[8] Claimants' lawyers are prohibited from charging the claimant a fee. 20 C.F.R. §725.365. Instead, they must seek a fee award, which is paid by the employer or the Trust Fund, but only if and when benefits are awarded and all appeals are exhausted, 20 C.F.R. §725.366, a process that often takes many years as the claims bounce back and forth among the adjudicatory levels.

This brief is filed in support of the argument of the Court-appointed amicus on severability: specifically, that if the "minimum coverage" provision is declared unconstitutional, the Court should sever it from the remainder of the ACA so that the amendments to the BLBA in Section 1556 remain intact.

SUMMARY OF ARGUMENT

Even if the minimum coverage provision of the ACA is declared unconstitutional, Section 1556 must be upheld because it is independent of every other section in the Act and fully operable as law. Section 1556 merely deletes limiting language that was first added to the BLBA in 1981. Before that time, the two substantive provisions of Section 1556 were in effect and upheld by the courts. Since passage of the ACA in 2010, the three Courts of Appeal that have considered the provisions in Section 1556 have found that they are constitutional. The normal rule upholding all but the invalid sections of a statute should be applied to Section 1556.

ARGUMENT

I. THE HISTORY OF THE BLBA SHOWS THAT SECTION 1556 MERELY REINSTATED PROVISIONS THAT WERE IN EFFECT BEFORE 1981.

Pneumoconiosis "encompasses a cruel set of conditions that affect a significant percentage of the nation's coal miners with 'severe, and frequently crippling, chronic respiratory impairment.'" *National Mining Ass'n*, 292 F.3d at 854, quoting *Turner Elkhorn Mining Co.*, 428 U.S. at 6. "The tragic consequences of [black lung disease] prompted Congress to authorize a special program for the benefit of its victims in 1969." *Mullins Coal Co. Inc. of Virginia v. Director, OWCP*, 484 U.S. 135, 138 (1988). The program was part of the 1969 Federal Coal Mine Act, which also established the first comprehensive standards limiting the amount of respirable coal mine dust in the mines in the wake of a mine explosion that killed 78 men.[9] The purpose of the program was to provide benefits to coal miners who were totally disabled at least in part by pneumoconiosis or other chronic lung diseases arising out of coal mine employment and to their survivors. *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 684 (1991).

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[9] Brian C. Murchison, *Due Process, Black Lung, and the Shaping of Administrative Justice*, 54 ADMIN. L. REV. 1025, 1038 (2002).

When the BLBA was initially enacted, Congress intended that the program's benefits, although modest, would be generously awarded. *Pothering v. Parkson Coal Co.*, 861 F.2d 1321, 1326 (3d Cir. 1988). But in practice, the burden on claimants to prove the elements of entitlement was so onerous that many claims were denied outright and many others stalled in the system. *See id.* Dissatisfied with the high rate of denials and the increasing backlog of unadjudicated claims, Congress in 1972 liberalized both the criteria for entitlement and the procedures. *Pauley*, 501 U.S. at 685, citing the Black Lung Benefits Act of 1972, Pub. L. No. 92-303, 86 Stat. 150 (1972). New sections were added to the BLBA that were designed to "[r]elax the often insurmountable burden of proving eligibility." S. Rep. No. 92-743 (1972), reprinted in 2 USCCAN 2305, 2306.

As relevant here, Congress created the rebuttable "15-year presumption" that workers who had spent at least 15 years in underground coal mines (or in substantially similar conditions in surface mines) and had a totally disabling respiratory impairment were rebuttably presumed to be totally disabled by pneumoconiosis, or to have died due to pneumoconiosis, and/or to have been totally disabled by pneumoconiosis at the time of death. Pub. L. 92-303, §4(b)(1); 30 U.S.C. §921(c)(4). So, for example, with this presumption, if a miner can prove that he or she has a totally disabling respiratory impairment after working at least 15 years in a coal mine, the miner is presumed to be totally disabled in part by black lung disease. The coal mine employer then has the opportunity to rebut the presumption with expert testimony that rules out coal mine dust as a contributing cause of the miner's respiratory impairment and attributes the impairment to something else entirely. Without the 15-year presumption, the miner bears the burden of showing that element of entitlement.

But despite the 1972 amendments, the denial rate remained high and many claims still languished due to long delays in adjudication, so Congress again amended the statute in 1977, further loosening the criteria for entitlement. *Pauley*, 501 U.S. at 687-88, citing the Black Lung Benefits Reform Act of 1977, Pub. L. 95-239 (1978), 92 Stat. 95. Congress's intent was to relieve the burden of proof on claimants generally and on widows in particular. *Pothering*, 861 F.2d at 1326-27, quoting S. Rep. No. 209, 95th Cong., 1st Sess. 18 ("Widows have been even more adversely and wrongfully affected by black lung claim denials than living miners....") As relevant here, the

1977 amendments provided that eligible surviving spouses of miners who had been awarded black lung disability benefits during their lifetimes were automatically entitled to survivor's benefits. The survivor did not have to prove independently that the miner's death was due to pneumoconiosis. Pub. L. 95-239, §7(h); 30 U.S.C. §932(l). The approval rate for such claims at the initial administrative level rose to 34%.[10]

In 1981, Congress reversed course and tightened the eligibility requirements for both miners and their survivors.[11] Pub. L. 97-119, 95 Stat. 1635 (1981). Among other things, the 1981 amendments added a clause to 30 U.S.C. §921(c)(4) that eliminated the 15-year presumption for claims filed after January 1, 1982. Pub. L. No. 97-119, §202(b)(1)-(2). Congress also added a clause to 30 U.S.C. §932(l) that eliminated automatic benefits for survivors of miners who had been awarded benefits during their lifetimes, for claims filed on or after January 1, 1982. Thereafter, survivors could generally only obtain benefits by initiating their own claims after the miner died and proving that the miner's death was caused by pneumoconiosis. Pub. L. No. 97- 119, §202(b)(1)-(2). Apart from the challenge of proving that pneumoconiosis was a contributing cause of the miner's death through expert medical opinion, survivors had to satisfy all the requirements for filing a new claim. This added years to the litigation process. The rate of approval at the initial agency level slumped to only 5% for claims filed between 1982 and 1994.[12]

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[10] Notice of Proposed Rulemaking, Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 62 Fed. Reg. 3338, 3357 (Jan. 22, 1997).

[11] Black Lung Benefits Act Amendments of 1981, Pub. L. 97-119, 95 Stat. 1635 (1981).

Despite the reduced dust standards mandated by the 1969 Federal Coal Mine Act, miners continued to develop totally disabling lung diseases.[13] The DOL revised the BLBA's implementing regulations in 2000 to, among other things: clarify that the definition of "pneumoconiosis" includes any chronic lung disease arising from coal mine employment; streamline the adjudication of claims; and limit the documentary evidence that the parties could submit in an effort to resolve disputed medical issues on the basis of the quality of the evidence, rather than the sheer volume of medical reports with which employers tended to deluge the record.[14]

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[12] Notice of Proposed Rulemaking, *supra*, fn. 10, at 3357.

[13] Modern mining techniques may increase the risk of lung disease because machines such as the continuous miner pulverize the coal, which increases the toxicity of the dust particles. Robert A.C. Cohen, M.D., Aiyub Patel, M.D., and Francis Green, M.D., *Lung Disease Caused by Exposure to Coal Mine and Silica Dust*, SEMINARS IN RESP. CRIT. CARE MED. 2008: 651-661.

In 2010, under the sponsorship of the late Senator Robert Byrd of West Virginia,[15] Congress included Section 1556 in "Miscellaneous Provisions" of Title I, Subtitle G of the ACA. Section 1556 is entitled "Equity for Certain Eligible Survivors" and is set out in footnote 16 in its entirety.[16] Section 1556 restored two provisions of the pre-1981 BLBA by deleting the limiting language that had been added in 1981.[17] Specifically:

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[14] Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, 65 Fed. Reg. 79,920, 80,030-32 (Dec. 20, 2000) (entitled "Need For and Objectives of, the Rule").

[15] West Virginia is one of the most important coal mining states, ranking only behind Wyoming in coal production. *See GAO Report*, supra, fn. 2, at 4.

[16] **SEC. 1556: EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.**
(a) REBUTTABLE PRESUMPTION.—Section 411(c)(4) of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is amended by striking the last sentence.
(b) CONTINUATION OF BENEFITS.—Section 422(l) of the Black Lung Benefits Act (30 U.S.C. 932(l)) is amended by striking ", except with respect to a claim filed under this part on or after the effective date of the Black Lung Benefits Amendments of 1981".
(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to claims filed under part B or part C of the Black Lung Benefits Act (30 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005, that are pending on or after the date of enactment of this Act.

> (a) Section 1556(a) deleted the language in 30 U.S.C. §921(c)(4) that eliminated the 15-year presumption for claims filed on or after January 1, 1982.
>
> (b) Section 1556(b) deleted the language in 30 U.S.C. §932(l) that eliminated automatic benefits for survivors of miners who were found to be entitled to disability benefits during their lifetimes, for claims filed after January 1, 1982.
>
> (c) Finally, Section 1556(c) limited the effective date of Sections 1556(a) and (b) to claims that were filed after January 1, 2005 and pending on or after March 23, 2010.

Thus, Section 1556's sole purpose was to restore these two provisions that had been in effect before the 1981 amendments to the BLBA, for those claims that were filed after January 1, 2005 and pending on or after March 23, 2010.

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[17] There were other presumptions that were once in the pre-1981 BLBA that were not restored by Section 1556.

II. SECTION 1556 IS NOT RELATED TO ANY OTHER PROVISION OF THE ACA AND THE STATUTORY PROVISIONS THAT IT REINSTATES ARE CONSTITUTIONAL AND "FULLY OPERATIVE AS LAW."

The foregoing discussion shows that Section 1556 exemplifies an entirely discrete statutory section that functions independently of the rest of the ACA. There is nothing in the text of Section 1556 that is in any way intertwined with the minimum coverage provision of the ACA — or indeed any other part of the ACA. Section 1556 thus should be upheld even if the Court finds that some other section of the ACA does not pass constitutional muster. *Free Enterprise Fund v. Pub. Co. Accounting Oversight Board,* 130 S.Ct. 3138, 3161 (2010) (if a provision is "fully operable as a law," it must be upheld "[u]nless it is evident that the Legislature would not have enacted those provisions... independently of that which is [invalid]." (Internal citations omitted.)

The Fourth Circuit came to precisely this conclusion in *West Virginia CWP Fund,* 2011 WL 6062116. The employer-fund had initially contended that Section 1556 could not be severed from the remainder of the ACA, but abandoned this position at oral argument after the Fourth Circuit upheld the ACA in *Virginia v. Sebelius*, 656 F.3d 253 (4th Cir. 2011), and *Liberty University Inc. v. Geithner*, __F.3d__, 2011 WL 3962915 (4th Cir. Sept. 8, 2011).

The Fourth Circuit then addressed severability in dicta, noting "we would uphold the validity of the BLBA amendments" in Section 1556 even if any other sections of the ACA were declared unconstitutional. *West Virginia CWP Fund,* at *3, n. 2.

In reaching this conclusion, the Fourth Circuit first cited "the normal rule ... that partial, rather than facial, invalidation is the required course, such that a statute may ... be declared invalid to the extent that it reaches too far, but otherwise left intact." *Id.*, quoting *Ayotte v. Planned Parenthood of N. New England,* 546 U.S. 320, 329 (2006). The Court then concluded that "the normal rule" would apply to Section 1556 because the amendments to the BLBA in Section 1556 "have a stand-alone quality and are 'fully operative as a law.'" *Id.*, quoting *Free Enterprise Fund v. Pub. Co. Accounting Oversight Board*, 130 S.Ct. at 3161.

The Fourth Circuit roundly rejected the employer-fund's speculation that Section 1556 would not have been passed unless it was included along with the minimum coverage provisions of the ACA, noting that such an argument

> threatens the separation of powers by inviting courts to scrutinize the process by which a coordinate branch of government goes about its business. Likewise, it invites every loser in a

> legislative fight to contest not only the constitutionality of Congress's final product, but the way that Congress went about enacting it.

West Virginia CWP Fund at 7.

It is, moreover, especially appropriate to apply the "normal" severability rule to uphold Section 1556 because the two provisions that Section 1556 reinstated are not newly conceived creations. As part of the pre-1981 BLBA, they were validated by the courts decades ago. In *Turner Elkhorn Mining Co.*, 428 U.S. 19-20, the Supreme Court upheld the constitutionality of the BLBA as a whole, including the 15-year presumption now restored by Section 1556(a). The Court rejected the coal industry's argument that the BLBA violated due process by imposing retroactive liability for disability and survivors' benefits on mine operators. Rather, the Court concluded, the statute was rationally related to a legitimate legislative purpose: "the imposition of liability for the effects of disabilities bred in the past is justified as a rational measure to spread the costs of the employees' disabilities to those who have profited from the fruits of their labor — the operators and coal consumers." 428 U.S. at 18.

The automatic survivor's benefits now in Section 1556(b), which was first added to the BLBA in 1978 as 30 U.S.C. §932(l), was also enforced by the courts. *See Pothering,* 861 F.2d at 1328 (holding that under 30 U.S.C. §932(l) as it existed before the effective date of the 1981 amendments, a survivor did need not to file a new claim for benefits if the miner was receiving benefits before he died). Thus, the two provisions that Section 1556 restored have already been tested and upheld.

The reinstated provisions in Section 1556 have also withstood constitutional challenges in the two years since the ACA was enacted. Every court that has considered the issue has rejected the coal industry's contention that the provisions in Section 1556 violate the Due Process and Takings Clauses of the Fifth Amendment. The Seventh Circuit upheld the 15-year presumption in Section 1556(a) in *Keene v. Consolidation Coal Co.*, 645 F.3d 844 (7th Cir. 2011), noting that "the rational purpose for applying the 15-year presumption retroactively is to give miners and their survivors whose claims were recently filed a better shot at obtaining benefits." *Id.* at 849.

In *B&G Construction Co., Inc. v. Director, OWCP,* 662 F.3d 233 (3d Cir. 2011), the Third Circuit upheld the constitutionality of the automatic survivor's benefits in Section 1556(b) in a detailed opinion that carefully considered the history of the amendments to BLBA. In *West Virginia CWP Fund,* the Fourth Circuit also considered a challenge to restored survivor's benefits in Section 1556(b), and agreed with the Third Circuit's analysis. The Fourth Circuit noted that — far from acting arbitrarily in enacting Section 1556, as the industry opponents had claimed — Congress used a measured approach by limiting application of Section 1556 to claims filed after January 1, 2005 and still pending on or after March 23, 2010. *Id.*, 2011 WL 6062116 at *4.

Petitioners are therefore flatly wrong in their broad assertion that Congress "crafted the entire [ACA] to function as a carefully-balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal." State Petitioners Br. on Severability, at 53 (italics and internal quotation marks omitted). On the contrary, it is evident that the provisions in Section 1556 do not work together with any other part of the ACA. The provisions in Section 1556 are not funded by any other part of the ACA. They are not intertwined with any other section of the ACA. Nor, as the Third Circuit noted in ***B&G Construction,*** 662 F.3d at 244, is there any pre-passage legislative history of Section 1556 that might tie it, even in theory, to any other part of the ACA, much less to "one legislative primary goal."[18]

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[18] Senator Byrd made a statement on the floor of the Senate two days after the ACA was passed, which concluded: "I look forward to working to ensure that claimants get a fair shake as they try to gain access to these benefits that have been so hard won." 156 Cong. Rec. at 2083S-84S (daily ed. March 25,

Rather, in restoring these provisions of the BLBA for claims filed after January 1, 2005 and pending on or after March 23, 2010, Congress manifestly intended to recalibrate the requirements of the BLBA to their pre-1981 status so that disabled coal miners and their survivors might find it less crushingly difficult to obtain black lung benefits.

The provisions in Section 1556 are thus "fully operable as law" without regard to the minimum coverage provision of the ACA. *See Free Enterprise Fund,* 130 S.Ct. at 3161. It certainly is not "evident" that Congress would not have reinstated the provisions in Section 1556 independently of the minimum coverage provision. *See Alaska Airlines Inc. v. Brock*, 480 U.S. 678, 684 (1987), quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976). The Court should therefore apply the "normal rule" of severability and leave Section 1556 intact.

2010)(statement of Sen. Byrd).

CONCLUSION

Even if the minimum coverage provision of the ACA is found to be unconstitutional, the Court should uphold Section 1556.

Respectfully submitted,

Grant Crandall
Arthur R. Traynor III
United Mine Workers
of America
18354 Quantico Gateway Dr.
Triangle, VA 22172
(703) 291-2400
gcrandall@umwa.org

Thomas E. Johnson*
Anne Megan Davis
Johnson, Jones,
Snelling, Gilbert
& Davis, P.C.
36 S. Wabash Ave
Chicago, IL 60603
(312) 578-8100
tjohnson@jjsgd.com
*Counsel of Record

Counsel for Amici Curiae

February 17, 2012

AMICUS
CURIAE
BRIEF

Nos. 11-393 & 11-400

In the Supreme Court of the United States

NAT'L FED. OF INDEP. BUSINESS, ET AL.,
Petitioners,
v.
KATHLEEN SEBELIUS, ET AL.,
Respondents.

STATE OF FLORIDA, ET AL.,
Petitioners,
v.
U.S. DEPT. OF HEALTH & HUMAN SVCS., ET AL.
Respondents.

On Writs of Certiorari to the U.S. Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* TEXAS PUBLIC POLICY FOUNDATION AND CATO INSTITUTE SUPPORTING PETITIONERS ON SEVERABILITY

Richard Epstein
800 N. Michigan Avenue
Apartment #3502
Chicago, IL 60611
(773) 450-4476

Ilya Shapiro
CATO INSTITUTE
1000 Mass. Ave., N.W.
Washington, DC 20001
(202) 842-0200
ishapiro@cato.org

Mario Loyola
Counsel of Record
Josiah Neeley
TEXAS PUBLIC POLICY FOUNDATION
900 Congress Ave.,
Suite 400
Austin, TX 78701
(512) 472-2700
mloyola@texaspolicy.com

QUESTION PRESENTED

Whether the individual mandate of the Patient Protection and Affordable Care Act is severable from Titles I and II if that mandate is found unconstitutional.

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INTEREST OF *AMICI CURIAE*[1]

The Texas Public Policy Foundation is a nonprofit public policy organization based in Austin, Texas. TPPF's mission is to defend liberty, personal responsibility, free enterprise, and limited government in Texas and across the nation. TPPF's Center for Tenth Amendment Studies was established to pursue the restoration of the Constitution's limits on the federal government, which are necessary for the protection of liberty.

Established in 1977, the Cato Institute is a nonpartisan public policy research foundation dedicated to advancing the principles of individual liberty, free markets, and limited government. Cato's Center for Constitutional Studies was established in 1989 to help restore the principles of limited constitutional government that are the foundation of liberty. Toward those ends, Cato publishes books, studies, and the annual *Cato Supreme Court Review*, conducts conferences, and files *amicus* briefs.

Various provisions of the Patient Protection and Affordable Care Act impede state sovereignty and individual liberty, limiting states' ability to chart their own course on matters relating to health care. Holding the entire Act unconstitutional would thus vindicate *Amici Curiae*'s missions. The severability issue also concerns *Amici Curiae* because it implicates the scope of judicial review and will clarify how judges are to apply statutes suffering from constitutional defects.

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[1] Pursuant to this Court's Rule 37.2(a), *amici* state that all parties have lodged blanket consents. Pursuant to Rule 37.6, *amici* state that no part of this brief was authored by any party's counsel, and that no person or entity other than *amici* funded its preparation or submission.

SUMMARY OF ARGUMENT

When a federal court finds unconstitutional only one part of a congressional act, it generally sustains the remainder, severing only the invalid part. But in doing so courts must remain faithful to Congress's intent in shaping the legislation. The basic principle of severability is thus subject to an important limitation: This Court, out of respect for the dignity of a coequal branch of the government, must avoid creating a law that Congress never adopted.

On March 23, 2010, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (collectively, "PPACA" or "the Act") was enacted into law. [2] Title I of the Act Deals with Quality, Affordable Health Care for All Americans. Title II addresses the role of public programs, and sets out a detailed program for expanded access to Medicaid. Section 1501 of Title I contains a mandate that individuals purchase health insurance or pay a tax penalty (the "individual mandate"). Many parties, including parties in this case, immediately challenged the constitutionality of the individual mandate and the manifold impositions that the expanded Medicaid programs impose on the states.

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[2] Citations herein are to the "consolidated print" of the Act, P.L. 111-148 as amended by P.L. 111-149.

The District Court below held both that the individual mandate was unconstitutional and that it could not be severed from the rest of the Act, *Florida v. HHS*, 780 F. Supp. 2d 1256 (N.D. Fla. 2011). The Court of Appeals agreed that the individual mandate is unconstitutional, but reversed the District Court's ruling on severability, and upheld the remainder of the Act. *Florida v. HHS*, 648 F.3d 1235 (11th Cir. 2011).

Amici Curiae take no position on whether the entire statute should be struck down if the individual mandate is found unconstitutional. The Court of Appeals was right to find that some portions of the Act are so independent from the provisions which depend on the mandate (Titles I and II) that they could survive *independent* constitutional challenge.[3] But the District Court was surely correct to decide that the individual mandate is so interwoven with Titles I and II that none of them could stand. The individual mandate was essential to the Act's scheme for achieving near-universal health care coverage at an acceptable cost. In its core provisions, the Act was designed to make health care more affordable and accessible. Whether the Act would have achieved those goals at an acceptable cost with the individual mandate is open to doubt. But the Act certainly will not achieve those goals once that provision is stripped from the Act; nor, without that provision, will the Act operate in anything like the manner intended by Congress.

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[3] See, *e.g.*, The Biologics Price Competition and Innovation Act of 2009, Title VII, Subtitle A of the Act, 124 Stat. 119, 804-821 (2010), codified in various sections of Titles 21, 35, and 42 ("BPCIA").

Severing the individual mandate from its related provisions in Titles I and II will produce new comprehensive health care legislation that Congress did not enact and would never have enacted. Virtually all of the health insurance reforms in Title I either strengthen the conditions for an "adverse selection spiral" (healthy people exiting the health insurance risk pool as premiums rise) or will not function as intended in conditions of adverse selection. The purpose of the individual mandate was to prevent such adverse selection, which had led to the failure of many state health care reform efforts.

The individual mandate is scarcely less tied into the provisions in Titles I and II related to Medicaid expansion and insurance premium subsidies. Those provisions were designed to work in tandem with the individual mandate to reduce the number of uninsured. But without the mandate, the reduction in the number of uninsured will be much smaller than projected under current law; the federal budget will be strained by larger-than-forecast premium support subsidies because the subsidies increase as premiums increase; and the insurance market for those not eligible for subsidies will be particularly subject to adverse selection. Hence the congressional objective of achieving affordable and accessible health care at an acceptable cost will be defeated by eliminating the mandate from the unified scheme of Medicaid, premium support, and individual mandate that was designed to achieve those objectives. The Court cannot repair a broken system, but must leave that task to Congress.

ARGUMENT

I. THE COURT CANNOT CREATE A NEW LAW THAT CONGRESS NEVER ENACTED

A. Severability Law Began with *Marbury v. Madison* and Involves a Two-Prong Test

In *Marbury v. Madison,* 5 U.S. (1 Cranch) 137 (1803), this Court struck down a single invalid clause of the lengthy Judiciary Act of 1789, which created the federal judiciary. *Id.* at 176. No other provision of the Judiciary Act depended on or was affected by the invalid clause, which was minor and entirely separate from the overall legislative scheme. Accordingly, the Court allowed the rest of the law to stand. Nearly two centuries later, the principles which guided the Court's decision in *Marbury v. Madison* are still in force.

In *Alaska Airlines v. Brock,* 480 U.S. 678 (1987), the Court considered the Airline Deregulation Act of 1978. That act provided certain benefits to airline workers laid off as a result of deregulation, including granting these workers right of first refusal on new airline job openings. It empowered the Secretary of Labor to issue implementing regulations, subject to a unicameral legislative veto of the type that had recently been struck down in *INS v. Chadha,* 462 U.S. 919 (1983). After concluding that the legislative veto was unconstitutional, this Court turned to the question of severability. This Court began by noting that when "an act of Congress contains unobjectionable provisions *separable* from those found to be unconstitutional, it is the duty of this court to so declare and to maintain the act *in so far as it is* *valid.*" 480 U.S. at 684 (*quoting Regan v. Time, Inc.*, 468 U.S. 641, 642 (1981) (*quoting El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909)) (emphasis added).

The Court then offered a concise articulation of its traditional two-prong severability test: "'Unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped *if* what is left is fully operative as a law.'" *Id.* (quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976) (per curiam) (in turn quoting *Champlin Refining Co. v. Corporation Comm'n of Oklahoma*, 286 U.S. 210, 234 (1932)) (emphasis added).

1. Is the remainder "fully operative as a law?"

Most instructively the Court clarified the phrase "fully operative as a law" in this fashion:

> Congress could not have intended a constitutionally flawed provision to be severed from the remainder of the statute if the balance of the legislation is incapable of functioning independently. *See, e.g., Hill v. Wallace*, 259 U.S. 44, 70-72 (1922) (holding the Future Trading Act nonseverable because the valid and invalid provisions were so intertwined that the Court would have to rewrite the law to allow it to stand)."

Id. This Court's explicit reference to *Hill* is crucial to the dispute over the individual mandate in its relation to both Title I and Title II. When unconstitutional and constitutional provisions are "so interwoven" "that they cannot be separated," *Hill*, 259 U.S. at 70, the provisions remaining after excision are not "operative" notwithstanding that they may have *some* legal effect on their own.[4]

If the effect of excising one provision is to upset Congress's intended balance, then the court has created a new "law" out of whole cloth—one that no Congress ever passed and no President ever signed. Such a remainder would not be a "valid" law. Even a severability clause "in no way alters the rule that in order hold one part of a statute unconstitutional and uphold another part as separable, they must not be mutually dependent upon one another." *Carter v. Carter Coal*, 298 U.S. 238, 313 (1936) (striking down mutually dependent price-fixing and labor regulations of a law). This is because even a severability clause "does not give the court power to amend the act." *Hill*, 259 U.S. at 71.

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[4] *Champlin's* shorthand phrase "fully operative as a law," cited in *Alaska Airlines* and subsequent cases, requires more than that the provision have *some* legal effect. This is clear from an examination of the authorities cited in *Champlin*. *See*, *Connolly v. Union Sewer Pipe Co.*, 184 U.S. 540, 565 (1902) ("if an obnoxious section is of such import that the other sections without it would cause results not contemplated or desired by the legislature, then the entire statute must be held inoperative"); *Pollock v. Farmers' Loan and Trust Co.*, 158 U.S. 601, 635 (1895) (law may be held partly "inoperative" only "where the parts are so distinctly separable that each can stand alone, and where the court is able to see, and to declare, that the intention of the legislature was that the part pronounced valid should be enforceable, even though the other part should fail. To hold otherwise would be to substitute, for the law intended by the legislature, one they may never have been willing by itself to enact"); *Regan v. Farmer's Loan & Trust Co.*, 154 U.S. 362, 395-96 (1894) (invalid provisions "may fail, and still the great body of the statute have operative force, and the force contemplated by the legislature in its enactment"); and *Field v. Clark*, 143 U.S. 649, 695-96 (1892) ("These different parts of the act, in respect to their operation, have no legal connection whatever with each other. [...]While, in a general sense, both may be said to be parts of a system, neither the words nor the general scope of the act justifies the belief that Congress intended they should operate as a whole, and not separately for the purpose of accomplishing the objects for which they were respectively designed").

Champlin's shorthand phrase "fully operative as a law," 286 U.S. at 234, thus highlights a vital constitutional element that may be wholly determined within the four corners of the act. The post-excision remainder must operate in a way that is consistent with the evident congressional design for those remaining provisions. Any provisions that are "dependent, conditional, or connected" with an invalid provision must fall along with it. *Allen v. City of Louisiana*, 103 U.S. 80, 84 (1881) (quoting *Warren v. Mayor of Charlestown*, 68 Mass. (2 Gray) 84, 99 (1854). Otherwise, the court will have created a new legal creature that does not meet the minimum constitutional requirements for a bill to become law. The cases cited as authority in *Champlin* clearly suggest that the post-excision remainder must not merely "operate," but they must "operate" as Congress intended.[5]

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[5] A valuable new commentary, Kenneth A. Klukowski, *Severability Doctrine: How Much of a Statute Should Federal Courts Invalidate?* 16 Tex. Rev. L. & Pol. 1 (2011), places the interdependence inquiry with the second step, which asks whether Congress would have passed the remainder of the law without the invalid provision. In this reading of the test, the first step looks only to the basic functionality of the post-excision remainder, and might be satisfied if the remainder has *some* legal effect. But that on its own would tell us nothing about what Congress intended, which has been the deciding

Applying this standard, the Court noted the peculiar status of legislative vetoes; by definition, if the veto is never exercised, the rest of the law will operate as Congress intended. *Id.* Similarly, in *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138 (2010), this Court found that tenure restrictions on an accounting oversight board were severable from the remainder of the act, which both preserved presidential appointment power and left the board "fully responsible" to both the oversight commission and to the president, just as Congress intended.

2. Would Congress have enacted the remainder?

Taking up the second part of the traditional severability standard, this Court in *Alaska Airlines* stated, "The final test, for legislative vetoes as for other provisions, is the traditional one: the unconstitutional provision must be severed unless the statute created in its absence is legislation that Congress would not have enacted." 480 U.S. at 685. In applying this severability prong , this Court examined text and historical context to see whether Congress would have achieved the same legislative bargain without the excised provision. *Id.*

This Court noted that the obligations imposed on the Secretary of Labor in dealing with displaced workers were "obviously designed merely to

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factor for this Court, as the cases cited in *Champlin* make clear. The second part of the severability test should instead focus on whether the text and historical context of the law make it evident that Congress would have reached the same legislative bargain without the excised provisions.

facilitate" the law's substantive provisions, and were thus "ancillary, "subsidiary," and "relatively insignificant." *Id.* at 688. It was apparent at every stage of the legislative process that such regulations were subordinate to the law's central mission, which was to soften the impact of deregulation on airline industry labor. *See generally id.* at 691-97.

In *Free Enterprise,* this Court gave further clarity on the second severability step. It held that the tenure restrictions on an accounting oversight board created by a comprehensive financial law were severable from the board itself because "nothing in the statute's text or historical context makes it evident that Congress, faced with the limitations imposed by the Constitution, would have preferred no Board at all to a Board whose members are removable at will." *Id.* at 3162 (internal quotations omitted). This Court concluded that the board provisions and related tenure restrictions were independent and separable; Congress would have reached the same legislative bargain even without the tenure restrictions, and would have retained the provisions which created the board.

B. The Eleventh Circuit Erred in Its Severability Analysis

In denying the intimate connection between the individual mandate and Titles I and II, the Court of Appeals misread this Court's decisions. The court moreover failed to understand the interrelation among the Act's key provisions, particularly among the individual mandate and those provisions with which it is most deeply interwoven: guaranteed issue and the prohibition on preexisting conditions exclusions.

The Court of Appeals first alluded to the finding in Section 1501(a)(2)(I) of the Act, which explains why those two insurance reforms would create an incurable problem of adverse selection without the individual mandate. 648 F.3d at 1332.

The feared scenario runs as follows. As a result of guaranteed issue, and with no reason to fear exclusion for preexisting conditions, healthy people would wait until they are sick to get coverage, thus diminishing the pool of insured and driving up premiums for those who retain their coverage. Those higher premiums in turn drive more healthy people out of coverage. As the reduction in the number of insured and rising premiums start to become mutually reinforcing, the insurance industry faces what health care analysts call the "adverse selection death-spiral." Jonathan Gruber, *Why We Need the Individual Mandate: Without a Mandate, Health Reform Would Cover Fewer with Higher Premiums*, Center for American Progress (April 8, 2010), http://www.americanprogress.org/issues/2010/04/pdf/individual_mandate.pdf. Accordingly, as the Court of Appeals noted, Congress explicitly found that the mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 648 F.3d at 1323 n. 138 (quoting Sec. 1501(a)(2)(I) of the Act).[6]

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[6] There is a consensus among policy experts that the individual mandate is "a central pillar of health reform. Without the

After thus plainly laying out the vital dependency between the insurance reforms (including "improved health insurance products") and the individual mandate, the Court of Appeals then concluded: "Our severability concern is not over whether the two reforms can 'fully operate as a law.' They can. Rather, our severability concern is only whether 'it is evident' that Congress 'would not have enacted' the two insurance reforms without the individual mandate." 648 F.3d at 1324 (quoting *Alaska Airlines*, 480 U.S. at 684).

But, as the Court's prior decisions show, *see supra* Part I.A.1, the operative test is never whether the remainder may have *some* legal effect, standing alone, for that would be true in all cases. Nobody disputes that the Act's insurance reforms will have *some* legal effect without the mandate; that "indicate[s] little about the intent of Congress regarding severability." *Alaska Airlines*, 480 U.S. at 685. But it will be an effect Congress never intended, and Courts must not "frustrate[] the intent of the elected representatives of the people."

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individual mandate, the entire structure of reform would fail." Jonathan Gruber, *supra* Part I.B. The consensus crosses the political spectrum. *See, e.g.*, Paul Krugman, *Do the Right Thing*, N.Y. Times, January 22, 2010, A31; Michael D. Tanner, *Bad Medicine: A Guide to the Real Costs and Consequences of the New Health Care Law*, Cato Institute (February 14, 2011), http://www.cato.org/pub_display.php?pub_id=11961;Ezra Klein, *The Importance of The Individual Mandate*, Wonkblog (Dec. 16, 2009 3:23 PM), http://voices.washingtonpost.com/ezra-klein/2009/12/draft_1.html; Janet Trautwein, *Why We Need A Strong Individual Mandate*, Wall Street Journal, (Nov. 10, 2009),http://online.wsj.com/article/SB10001424052748704402404574525923255957640.html.

Regan, 468 U.S. at 652. The courts cannot, by judicial fiat, create a new law that no Congress ever enacted and no president ever signed.

The Court of Appeals also erred in applying the second inquiry of the severability analysis—whether Congress would have adopted the related remainder without the individual mandate. It stated that "none of the insurance reforms, including even guaranteed issue and coverage of preexisting conditions, contain any cross-reference to the individual mandate or make their implementation dependent on the mandate's continued existence." *Florida v. HHS*, 648 F.3d at 1324. But the key findings for the individual mandate *do* contain critical cross-references to the related health insurance reforms, and they explicitly state that the implementation of the provisions referred to *is* dependent on the mandate. Section 1501(a)(2)(I) of the Act specifically refers to the health insurance reforms in Sections 2704 and 2705 of the Public Health Services Act, 42 U.S.C. §§ 300gg et seq., as well as to "improved health insurance products," a reference to the myriad of insurance reforms in Title I. That finding stresses that "if there were no requirement, many individuals would wait to purchase health insurance until they need care." Section 1501(a)(2)(I). Striking down the mandate while sustaining the provisions that Congress designed to be vitally dependent on it thus defeats the unified purpose of the law.

The Court of Appeals sought to defend that rash conclusion by noting that "a basic objective of the Act is to make health insurance accessible and thereby to reduce the number of uninsured persons." 648 F.3d at 1324-25. The court then concluded, "Undoubtedly, these [health insurance] reforms seek to achieve those objectives. All other things being equal, then, a version of the Act that contains these two reforms would hew more closely to Congress's likely intent than one that lacks them." Id. at 1325. This conclusion is manifest error. The question is not whether a court or some independent policy maker could view the preexisting conditions and guaranteed issue provisions as freestanding provisions unrelated to the mandate. The question is whether Congress so thought. On that the answer is unequivocal. As Congress was at pains to explain, Sec. 1501(a)(2)(I) of the Act, the insurance reforms would not achieve their objective and would not operate as intended without the mandate.

The court compounded its initial error by citing numerous other provisions "that also serve to reduce the number of the uninsured," including the health insurance reforms themselves! 648 F.3d at 1325. In so doing it substituted its judgment about the interrelation of these provisions for Congress's assertion that they were part of a single plan. Unlike in *Alaska Airlines*, both the text and historical context of the Act make clear that the individual mandate was essential to the legislative bargain.

The lower court correctly points out that some parts of the Act bear little relation to the individual mandate, compared with the insurance reforms.[7] In this brief *Amici Curiae* take no position on the parts of the Act that fall outside Titles I and II. The focus of this brief rather is to illuminate for the Court just how deeply and inextricably interwoven Titles I and II are with the individual mandate. As a detailed examination of those provisions shows, Congress presupposed that they would stand or fall together, given that the individual mandate is necessary for the health insurance reforms to operate as intended, and that it is designed to work *in tandem* with Medicaid and premium support to make health care more accessible and affordable.

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[7] *See, e.g.*, BGCIA, *supra* n. 3.

II. THE INDIVIDUAL MANDATE IS OPERATIVELY INSEPARABLE FROM TITLES I AND II OF THE ACT

The core of the Act is in its first two titles, which provide for a sweeping program of health insurance reforms, state-based insurance exchanges, and expanded Medicaid and premium support benefits. Titles I and II are primarily responsible for projections that the law will dramatically decrease the number of uninsured. Subsequent titles of the Act are generally ancillary to the first two titles.

Virtually all the provisions in Titles I and II were designed to depend upon or dovetail with the individual mandate. Without the mandate they will have an operation and effect entirely different than what Congress intended—in many cases, the opposite of what Congress intended.

At the time the Act was signed into law, the Congressional Budget Office estimated that without the Act, by 2019 the United States would have 55 million uninsured persons out of a total nonelderly population of 282 million, and estimated that the Act would reduce the number of uninsured by 33 million by 2019. CBO, *Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 20101 (P.L. 111-152)* (March, 2011), http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf. CBO subsequently estimated that, stripped of the mandate, the Act would reduce the number of uninsured by only about 16 million. CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, (June 16, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/Eliminate_Individual_Mandate_06_16.pdf.

In other words, CBO estimated that, with the mandate, the Act would reduce the number of uninsured by about two-thirds, but without it, by only about one-third. Hence, at the time the Act passed, Congress could have expected that stripping the mandate would reduce the overall impact of the Act on the uninsured population by half. Some economists estimate that without the mandate, reductions in the number of uninsured will be far lower. *See, e.g.*, Gruber, *supra* Part I.B.

Stripped of the mandate, the Act would also cause a dramatic rise in premiums. According to one estimate, individual insurance premiums could rise 40 percent higher without the mandate. *Id.* And, as explained *infra* Part II.A, premiums would rise for group plans as well.

A. Provisions with an Operative Dependency on the Individual Mandate

Title I of the Act consists mainly of health insurance reforms that, without the mandate, will create, or exacerbate, an adverse-selection spiral, and increase fiscal pressure on the government as a result of premium-support subsidies. Virtually all of these provisions take effect in 2014, coincident with the individual mandate.

1. “Guaranteed Issue”

Prior to the Act, *group* health insurance plans (about 90 percent of the insurance market) were subject to a guaranteed-issue requirement[8] under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, 110 Stat. 1936 (“HIPAA”). In order to forestall the expected adverse selection spiral, HIPAA allowed exclusions for pre-existing conditions, up to 12 months generally. Because allowing insurance companies to exclude unhealthy people from the rolls helps to avert an adverse selection spiral, this scheme allowed HIPAA to avoid having to impose an individual mandate.

The Act supplants the HIPAA scheme. Effective 2014, Sections 1201(4) and 1202(2)(A) of the Act provide for guaranteed issue *and* a prohibition on pre-existing conditions exclusions in all cases, respectively. Because the ban applies to group insurance plans under HIPAA in addition to the individual market, it creates an incentive for many of those who are *already covered* under employer-provided group insurance to drop insurance and wait until they get sick to buy health insurance. Consequently, under the Act adverse selection pressure affects the whole nonelderly population, including those who are already insured under employer-provided group insurance; hence the need for a broad insurance mandate.

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[8] HIPAA imposed no such limitation on individual plans (approximately the remaining 10 percent).

CBO estimates that as a result of eliminating the health care mandate, 16 million more people will be uninsured than under the Act in its original form:

> That increase in the number of people who are uninsured relative to current law would be the net result of about 4-5 million fewer individuals with employer-sponsored coverage, about 5 million fewer people with coverage obtained in the individual market (including individual policies purchased in the exchange or directly from insurers in the non-group market), and about 6-7 million fewer individuals with Medicaid or CHIP coverage.

CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, *supra* Part II.

One immediate effect of so many millions of healthy people dropping coverage will be to raise the per-unit costs of insuring those who remain in the pool. The price rise could be as high as 40 percent or higher. Gruber, *supra* Part II.B. Nobody can say with certainty, however, because rising premiums will accelerate the shrinking population of healthy people and vice versa, until the adverse selection spiral rests at some new equilibrium. After many of the state reform efforts, that equilibrium was reached only when virtually all insurers had left the individual market. *See*, *infra* Part III.B.

There is nothing in the record that suggests the individual mandate could have done the yeoman work that is intended for it. Indeed, the experience of state reform efforts suggests that neither the preexisting conditions exclusions prohibited by the Act nor even the individual mandate is entirely effective in preventing an adverse selection spiral as a result of guaranteed issue and similar insurance reforms. *See infra* Part III.B. The adverse selection could still take place with the mandate on the books. But this Court's task in a severability context is limited to the interrelation of the provisions in question, not the separate question of whether the Act can make good on its extravagant promises. To Congress, the health insurance reforms and the individual mandate were irretrievably interwoven. They are inseparable.

2. "Community Rating" compression

Effective in 2014, Section 1201(4) of the Act limits insurers to an age-based variation in premiums of no more than three to one. Because the eldest non-Medicare- eligible adults consume about five times more health care than youngest adults, the effect of this provision is to compress age-related premium variations, lowering premiums for the elderly and raising premiums for the young. Edmund Haislmaier, *Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets*, Heritage Foundation (Jan 20, 2011), http://thf_media.s3.amazonaws.com/2011/pdf/wm3111.pdf.

According to Haislmaier, *id.*, a three-to-one compression in age-related premiums variations would increase premiums for those aged 18 to 24 by 45 percent and those aged 15 to 29 by 35 percent, while reducing premiums for those aged 55-59 by 12 percent and those aged 60 to 64 by 13 percent.

Because the adverse selection spiral results from healthy (and typically, younger) people waiting until they get sick to get health insurance, the Act's age rating compression provisions, which artificially raise insurance premiums for that very population, will dramatically add to adverse selection pressures.

3. Provisions that increase the cost of insurance

Most of the Act's insurance product reforms tend to increase the cost of insurance. Because upward pressure on prices is one of the basic drivers of the adverse selection spiral, anything that increases such upward pressure will aggravate the adverse selection spiral. Absent the individual mandate, this will affect particularly those who are not eligible for premium support; and with respect to those who are, the government will feel the fiscal brunt of increased premium support. Still other reforms will increase the number of uninsured outright.

a. Prohibition on annual limits

Effective 2014, Section 1001(5) of the Act prohibits insurers from imposing "annual limits on the dollar value of benefits for any participant or beneficiary." This provision will eliminate many of the limited-benefit and health-reimbursement arrangements currently offered by employers with disproportionately low-wage workforces. The Act is designed to accommodate low-wage workers through Medicaid and premium-support provisions. Without the mandate, however, Congress believed that many of these currently insured would become uninsured. Because these individuals tend to be working-age and healthier, the relative proportion of healthy people in the insured risk pool would diminish, artificially aggravating adverse selection pressures.

b. Comprehensive coverage requirement

Section 1302(a) of the Act requires the Secretary of HHS to establish minimum "Essential Health Benefit" standards, to include specified elements typically associated with comprehensive coverage. Given the statutory minimum requirements, those plans are likely to increase average premiums in both the group and individual markets.

c. Limitation on cost-sharing

Section 1302(c) of the Act imposes cost-sharing restrictions on group health plans. Individuals currently enrolled in plans with cost-sharing provisions beyond those maxima will see their cost-sharing reduced and premiums correspondingly increased. Reduced cost-sharing will also encourage greater use of health services, which will further drive up premiums.

d. Preventive care coverage requirement

In addition to the coverage required by the "Essential Health Benefit" provisions, the Act requires group and individual plans to provide preventive services without enrollee cost sharing. *See, Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act.* 75 Fed. Reg. 41726 (July 19, 2010). The effect will be to increase premiums through the shifting of cost-sharing to the insurers, *and* to encourage increased overuse of preventive care services, which will also increase premiums.

B. Provisions Designed to Dovetail with the Individual Mandate

The Act's combination of individual mandate, Medicaid benefits, and sliding scale insurance premium support creates four general income brackets. The lowest is eligible for Medicaid and exempt from the mandate; the next highest is both eligible for Medicaid and subject to the mandate; the next is eligible for a sliding scale subsidy and subject to the mandate; and the highest is eligible for no benefit and is subject to the mandate.

The individual mandate thus operates in tandem with the Act's Medicaid expansion and sliding-scale premium support to increase access and affordability across income categories. Eliminating the mandate will dramatically skew this coverage, resulting in the concentration of large numbers of uninsured in particular income categories. Without the mandate, the Act's Medicaid and premium support provisions will fail to accomplish Congress's purpose of comprehensively expanding access and affordability of health care for all Americans.

1. Insurance exchanges

The Act provides for state-based exchanges where individuals will be able to purchase individual health insurance. The Act's premium support provisions in turn subsidize the purchase of insurance within the exchanges.

According to CBO estimates, most of the increase in the uninsured population that will result from elimination of the mandate will come among those who are eligible for subsidies (from 133 percent FPL to 400 percent FPL) and among those who are ineligible for the subsidies (above 400 percent FPL). *Explaining Health Care Reform: Questions about Health Insurance Subsidies,* Kaiser Family Foundation (April, 2010), http://www.kff.org/healthreform/upload/7962-02.pdf. The individual market for both populations will be organized under the exchanges. As the experience of state reform efforts shows, *see infra* III.B, guaranteed issue, community rating, and similar reforms pose grave risks to the individual market even with a robust individual mandate, and Congress knew from the states' experience that the risks could be catastrophic without the mandate.

In most of the states where health insurance reforms similar to those in the Act were attempted without an individual mandate, the individual health insurance industry virtually disappeared in just a few years as a result of adverse selection. *See infra* Part III.B. The Act's complex provisions related to state exchanges would certainly be pointless with the individual insurance industry in danger of collapse.

Moreover, if the individual mandate is struck down along with its most intimately related provisions, e.g., the ban on preexisting conditions exclusions, underwriting criteria based on health status would come back into the insurance application process, making the "pricing" mechanism of the exchange highly notional, and thereby defeating the purpose of the exchange from the consumer's point of view. Bradley Herring, *An*

Economic Perspective on the Individual Mandate's Severability from the ACA, The New England Journal of Medicine (March 10, 2011) http://www.nejm.org/doi/full/10.1056/NEJMpv1101519. A proper understanding of how the exchanges work in relation to other aspects of Titles I and II of the Act reveals that the legislative bargain which produced PPACA's central regulatory scheme was highly interwoven.

2. Medicaid expansion and premium subsidies

The Medicaid expansion and premium support provisions of the Act are designed to work in tandem with the individual mandate to spread health insurance coverage across income categories. According to CBO, the number of uninsured will drop by only one-third without the individual mandate, as opposed to the projected two-thirds with the individual mandate. The increase in the number of uninsured without the mandate would include 5 million fewer people with coverage obtained in the individual market, and 6-7 million fewer people eligible for Medicaid or CHIP. CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance*, *supra* Part II.

Adverse selection could dramatically increase the numbers of uninsured beyond CBO estimates, however, particularly for those in the individual market who are not eligible for subsidies (above 400 percent FPL). In many of the states that adopted guaranteed issue and community rating provisions, the market for such individuals was virtually wiped out in just a few years after adoption of the reforms.

See, infra III.B. But as CBO projections make clear, even among those eligible for subsidies and Medicaid or CHIP, millions will decline to enroll in coverage absent the mandate. The result—an uncertain fiscal impact, millions more without health insurance, and rising premiums—will upend the careful balance that Congress sought to achieve through its combination of Medicaid expansion, premium support, and individual mandate.

3. Reduced funding for safety-net hospitals

Federal law ensures emergency room care for low-income individuals. This requirement affects hospitals in low-income areas disproportionately. Federal law has long provided for supplemental payments to these "disproportionate share hospitals" (DSHs) under the Medicaid and Medicare programs. Because the Act was expected to reduce the number of uninsured by two-thirds, it accordingly reduces the funds available for DSH payments. Without the individual mandate, the reduction in the number of uninsured will be far lower (a third, or even less), CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance, supra* Part II, thus putting DSHs in financial jeopardy.

In sum it is evident from this close examination of the Act, which barely passed Congress, that it would have not been able to make it through without inclusion of the individual mandate. So long as the test for severability requires this Court strike down provisions that Congress has linked to the passage of the independent mandate, Title I and Title II should be struck down.

III. THE TEXT AND HISTORICAL CONTEXT OF THE ACT MAKE IT EVIDENT THAT CONGRESS WOULD NOT HAVE PASSED THE ACT WITHOUT THE INDIVIDUAL MANDATE

A. The Act's Text Shows that Congress Would Not Have Passed the Legislation without the Individual Mandate

Title I contains all of the key health insurance reforms: guaranteed issue, prohibition of preexisting conditions exclusions, enhanced benefits, state-based exchanges, premium subsidies, and the individual and employer mandates. Considered as a comprehensive legislative bargain, it is obvious that individual and employer mandates had no other purpose than to spread the costs of the preceding benefits among a large risk pool, and thereby avoid the consequence the benefits were sure to have on their own, namely that of an adverse selection spiral. The mandates are designed to implement the insurance reforms, and are as textually essential to each other as the regulations and related tax penalty in *Hill*, 259 U.S. at 44 (1922).

B. The Historical Context of State-Based Health Reform Efforts Shows that Guaranteed Issue and Community Rating Reforms Would Lead to Adverse Selection without An Individual Mandate

Before Congress took up health care reform in 2009, a handful of states had experimented with major health insurance reforms including guaranteed issue and some form of community rating compression, focused on the individual insurance market.[9] These reform efforts generally had disastrous effects: States experienced adverse selection spirals, with increased numbers of uninsured, large premium increases, and insurers exiting the individual market. *See*, Conrad F. Meier, *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States*, The Council for Affordable Health Insurance and The Heartland Institute (2005), http://www.cahi.org/cahi_contents/resources/pdf/destroyinginsmrkts05.pdf. This "historical context" explains why Congress would never have passed the Act without the individual mandate.

In each of these cases, state law generally permitted exclusions for preexisting conditions in the individual market. As the experience of HIPAA showed in the group market, allowing such exclusions could significantly attenuate the adverse selection problem. These state level experiments offer a particularly telling aspect of the historical context for the Act, which prohibits such exclusions altogether, thereby increasing the pressure for adverse selection, and leaving little alternative to an individual mandate beyond wholesale subsidies of health insurance.

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[9] Before the Act, the employer-provided group insurance market was largely regulated by federal law—HIPAA and ERISA. That left only the individual insurance market open to state regulation.

New Hampshire and Kentucky both adopted guaranteed issue and community ratings reforms in 1994. N.H. Rev. Stat. Ann. §420-G, P.L. 1994 c. 294; Ky. Rev. Stat. Ann. §304.17A, P.L. 1994 c. 512. In both states, adverse selection set in in the individual market almost immediately. *See* Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, pp. 5-6, 20 Milliman (July 10, 2007), http://alankatz.files.wordpress.com/2007/09/-milliman-study-on-gi-20070912.pdf. In New Hampshire both reforms were repealed in 2002, replaced by a high-risk pool for the commercially uninsurable. *Id.* at 20. In Kentucky, more than 40 insurers left the individual market within just two years, leaving just two insurers (one of them state-run) offering individual insurance; the state repealed the guaranteed issue and community ratings reforms in 1998 and declared a moratorium on mandated benefits in 2004. *Id.* at 5-6.

Similarly, individual insurance market guaranteed issue and community rating reforms were adopted in Vermont (1992), Washington (1993), and New Jersey (1992), with the same result: an adverse selection spiral, increased numbers of uninsured, skyrocketing premiums, and the virtual disappearance of the individual market. Title 8 V.S.A. §4080b (1992), 1991 Adj. Sess. No. 160 (Vermont); RCW 48.43, L. 1993 c. 492 (Washington); NJ ST §17B:27A, P.L. 1992 c. 161 (New Jersey); *see generally*, Wachenheim & Leida, *supra*, pp. 25-27, 36-43. In 1999, Washington significantly weakened its guaranteed issue provision by allowing insurers to exclude the sickest 8 percent of the population, who were instead offered a high risk pool. *Id.* at 42. In Vermont, deductibles were allowed to increase dramatically from $50 prior to reform; by 2006 the lowest indemnity deductible available in Vermont was $3,500. *Id.* at 37. In New Jersey, a 2003 reform allowed insurers to offer minimal benefit plans with similarly high deductibles, which tempted insurers back into the individual market.

Similar guaranteed issue and community rating reforms were adopted in New York (1993), and Maine (1993) with the same results as elsewhere. 11 NYCRR Parts 360-62, NY INS §3231, P.L. 1992 (New York); Me. Rev. Stat. Ann. Tit. 24-A §2736-C, P.L. 1993 c. 477 (Vermont). Adverse selection set in immediately, driving most insurers out of the individual insurance market and dramatically driving up premiums. Wachenheim & Leida, *supra*, pp. 10-14, 31-35. In response Maine adopted a state-based health insurance program (the Dirigo Health Reform Act of 2003) which in turn was repealed in June 2011. In Maine, New Jersey, and New York a losing struggle against the unintended consequences of their reform efforts was overtaken by the Act's passage.

The individual mandate grew out of the experience of Massachusetts, which adopted its guaranteed issue and community rating reforms in 1996. Mass. Gen. Laws. Ann. Ch. 176M §§ 2 and 4, P.L. 1996 c. 203. Adverse selection set in, shrinking the size of the individual insurance market as elsewhere. Wachenheim & Leida, *supra*, pp. 15-16. In 2006, the state adopted a major series of reforms that included an individual mandate, a state exchange for individual insurance plans, and several high-deductible, limited-benefit options to entice healthy individuals back into the insurance pools. *Id.* at 16. The mandate's initial success in initially arresting and reversing the adverse selection spiral provided what Congress could only have thought was vital information when it took up health reform in 2009 and 2010, namely that an individual mandate was an effective way to counteract the adverse selection spiral that, if history was any guide, would inevitably result from guaranteed issue and community rating provision—particularly with a prohibition on preexisting conditions exclusions.

Given this historical context, it is simply not believable that Congress had any intention of repeating the costly mistakes of the states, by adopting even more sweeping health insurance reforms without the balancing of an individual mandate.

C. At Every Point in the Legislative Process, Congress Gave the Individual Mandate the Highest Priority and Would Not Have Passed the Act without It

Shortly after the 2008 election, Senator Max Baucus released a white paper, *Call to Action: Health Reform 2009*, laying out the broad outlines of what would form the basis of the Act. Among six principles laid out in the Baucus paper was "Individual Responsibility," requiring all individuals to maintain health insurance coverage: "Once affordable, high-quality, and meaningful health insurance options are available to all Americans, it will be each individual's responsibility to have coverage. This step is necessary to make the entire health care system function properly." *Id.* at 13.

In the summer of 2009, the Senate Finance Committee held hearings on various aspects of health care reform. From the beginning, these hearings discussed the importance of a mandate as a means of making other elements of the health care reform package work as intended. *See, e.g., The President's Fiscal Year 2010 Health Care Proposals: Hearing Before the S. Committee on Finance*, 111th Cong. (2009).

On September 16, 2009, Senator Baucus released his Chairman's Mark of the Finance Committee health care reform bill, titled "The America's Healthy Future Act." The Chairman's Mark included an individual mandate. Several opponents of the bill objected to the inclusion of an individual mandate in the law, citing concerns over the provision's constitutionality as well as other concerns.

Several attempts were made during the Committee markup to strip or dilute the mandate provision. Senator Orin Hatch offered an amendment to eliminate the individual mandate altogether. This was tabled. Senator Charles Grassley offered an amendment that would have allowed states to opt out of the mandate requirement. This was rejected 10-14. Senator Bunning offered an amendment allowing individuals to opt out of the mandate upon request. This was defeated 9-14. An amendment by Senator Hatch to stay implementation of the individual mandate until judicial review of its constitutionality was ruled non-germane by a vote of 7-9. Finally, Senator Mike Crapo offered an amendment that would have exempted individuals making less than $200,000 a year and families making less than $250,000 a year from the mandate requirement. This was defeated 11-12. *See, Markup on Health Care Overhall: S. Committee on Finance*, 111th Cong. (2009).

Through votes in its principal committee of jurisdiction, the Senate thus repeatedly expressed the priority it placed on the individual mandate. Throughout, Senator Baucus vigorously defended the necessity of the individual mandate. For example, in response to Senator Jim Bunning's amendment allowing individuals to opt out of the mandate upon request, the Chairman stated, "I'd say it's a mortally wounding amendment because it basically says no more personal – or no shared responsibility for individuals . . . individuals will opt themselves out and that's going to undermine this whole system here. It clearly is going to undermine the system. The system won't work if this amendment passes." *Markup on Health Care Overhall, Part 3: S. Committee on Finance*, 111th Cong. (2009). Likewise, in response to Senator Crapo's amendment, Senator Baucus declared: "This is a killer amendment. This is an amendment which guts and kills health reform." *Markup on Health Care Overhaul, Part 7: S. Committee on Finance*, 111th Cong. (2009).

Senator Jeff Bingaman likewise noted that "it would seem to me that if you took away the requirement for–of an individual mandate you'd have–the expectation would have to be that a lot fewer people would wind up getting coverage . . . the ultimate effect of this would be that – would be that in states that took this option [that is, that opted out of the individual mandate] you would have to expect insurance premiums to be higher than in states that did not." *Markup on Health Care Overhall, Part 3: S. Committee on Finance*, 111th Cong. (2009).

On October 13, the bill was favorably reported out of Committee by a vote of 14-9. Thereafter, the individual mandate was discussed and debated extensively on the floor of the Senate prior to passage. As in committee, during discussion of the bill Senators repeatedly noted the importance of the mandate as a cost saving measure necessary to offset other aspects of the bill. *See, e.g.*, Cong Rec. S10447 (daily ed. Oct. 15, 2009) (statement of Senator Lamar Alexander) ("[O]ne does not have to be an actuary to figure this out. If the individual mandate is weaker, premiums will go up."); S10448 (daily ed. Oct. 15, 2009) (statement of Senator Alexander) ("We want to read the bill and know what it costs . . . . If it weakens the individual mandate; if it says young people can't buy inexpensive policies anymore; if it says millions of us have to buy government-approved, richer policies instead of policies with high deductibles; and if it imposes $955 billion of taxes that will be passed on, raising our premiums; if it raises our premiums instead of lowering our premiums, then why are we doing this?"); S11897 (daily ed. Nov. 20, 2009) (statement of Senator Tom Coburn) ("Then we have the insurance mandate. What is wrong? If, in fact, you have a preexisting illness, you don't get insured.

That is wrong. We need to fix that."); S10002 (daily ed. Oct 1., 2009) (statement of Senator Alexander) ("Coverage for all is also an essential element of health care reform and I believe an enforceable and effective individual mandate, combined with guaranteed insurance of insurance, is the best way to accomplish this goal. The individual mandate must provide effective incentives to help prevent adverse selection that could occur if the mandate is too weak."); S13577 (daily ed. Dec. 20, 2009) (statement of Senator Coburn) ("One of the big 'shall also's' that I do not think will ever hold scrutiny before the Supreme Court is, you shall buy an insurance policy. That doesn't fit anywhere in the Constitution that I read. If you do the legal research on it, as my staff lawyers from the Judiciary Committee have done, it is highly unlikely that will ever hold up. So the whole premise of a large portion of the taxes collected in this bill will be out the window. It will also change, through adverse selection, all of the insurance premiums in the country because, if you do not have an individual mandate making people buy insurance, the costs relative to the illness and the age, even though we have compressed the ratios, will rise exorbitantly.")

On Christmas Eve 2009, the health care bill, now HR 3590, passed the Senate on a vote of 60-39. H.R. 3590 111th Cong (2009). A previously passed House version also included an individual mandate in the form of a surtax on all individuals not maintaining health insurance coverage. H.R. 3200, 111th Cong. (2009). The House then took up the Senate-passed version, and again repeated reference was made to the individual mandate. Comments by California Rep. George Miller are perhaps most telling:

> The bill contains an individual mandate to either obtain health insurance or pay a penalty . . . Without an individual mandate, individuals could wait to purchase health insurance until they are sick – thereby driving up insurance costs and undermining the bill's efforts to bring health care costs and costs to the broader economy under control. This requirement spreads risk to ensure lower costs for everyone, prevents adverse selection, helps end overpayment by the government and other consumers for the uninsured, and makes health care reform overall sustainable.

156 Cong Rec. H1882 (daily ed. March 21, 2010) (statement of Rep. Miller).

On March 21, 2010, the bill, including the individual mandate, passed the House on a very narrow vote of 219-212.

CONCLUSION

For the foregoing reasons, if this Court rules the individual mandate unconstitutional, it should rule that the mandate is not severable from Titles I and II, and strike them down with the mandate.

Respectfully submitted,

Richard Epstein
800 N. Michigan Avenue
Apartment #3502
Chicago, IL 60611
(773) 450-4476

Ilya Shapiro
CATO INSTITUTE
1000 Mass. Ave., N.W.
Washington, DC 20001
(202) 842-0200
ishapiro@cato.org

Mario Loyola
Counsel of Record
Josiah Neeley
TEXAS PUBLIC POLICY
FOUNDATION
900 Congress Ave.,
Suite 400
Austin, TX 78701
(512) 472-2700
mloyola@texaspolicy.com

Counsel for Amici Curiae

January 5, 2012

AMICUS
CURIAE
BRIEF

No. 11-400

In the Supreme Court of the United States

STATE OF FLORIDA, ET AL.,
Petitioners,
v.
U.S. DEPT. OF HEALTH & HUMAN SVCS., ET AL.
Respondents.

On Writ of Certiorari to the U.S. Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* TEXAS PUBLIC POLICY FOUNDATION AND 36 TEXAS STATE LEGISLATORS SUPPORTING PETITIONERS ON MEDICAID

Richard Epstein
800 N. Mich. Ave, #3502
Chicago, IL 60611
(773) 450-4476
richard.epstein@nyu.edu

Mario Loyola
Counsel of Record
TEXAS PUBLIC POLICY FOUNDATION
900 Congress Ave.
Austin, TX 78701
(512) 472-2700
mloyola@texaspolicy.com

QUESTION PRESENTED

Whether the Medicaid expansion provisions of the Patient Protection and Affordable Care Act are impermissibly coercive of State governments.

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INTEREST OF *AMICI CURIAE*[1]

Title II of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (collectively, the "ACA")[2] contains Medicaid expansion provisions that will dramatically increase the fiscal burdens on States while drastically limiting their regulatory autonomy in providing healthcare. These burdens will fall disproportionately on Texas, where General Revenue Medicaid spending is projected to increase under the ACA by 48.7 percent in the first ten years, more than in any other State. Jagadeesh Gokhale, *The New Health Care Law's Effect on State Medicaid Spending*, April 6, 2011, at 6.[3]

The mission of the Texas Public Policy Foundation (TPPF) is to defend liberty, personal responsibility, free enterprise, and limited government in Texas and in the nation as a whole. Because these goals will be substantially undermined by the Medicaid expansion provisions of the ACA, TPPF has an interest in this Court's determination of the validity of those provisions, and urges this Court to invalidate those provisions under the United States Constitution.

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[1] Pursuant to this Court's Rule 37.2(a), *amici* State that all parties have lodged blanket consents. Pursuant to Rule 37.6, *amici* State that no part of this brief was authored by any party's counsel, and that no person or entity other than *amici* funded its preparation or submission.

[2] Citations herein are to the "consolidated print" of the ACA, P.L. 111-148 as amended by P.L. 111-149.

[3] Available at http://www.cato. org/store/reports/new-health-care-laws-effect-State-medicaid-spending-study-five-most-populous-states.

The remaining *Amici Curiae* are members of the Texas House of Representatives seeking the invalidation of the Medicaid expansion provisions of the ACA in the hopes of remaining able to represent their constituents.

SUMMARY OF THE ARGUMENT

This case raises the most profound questions of federal-State relations since the New Deal constitutional settlement of the 1930s. That settlement held that the federal government could regulate first and foremost those matters that fell within a broad reading of the Commerce Clause. But it also recognized that the States were coordinate sovereigns that enjoy their independent place within the federal system.

That position has been recognized in recent years in *New York v. United States*, 505 U.S. 144 (1992), and *Printz v. United States*, 521 U.S. 898 (1997), both of which limit the ability of the federal government to dictate the actions of either the State legislature or the State executive. The level of federal intrusion into State activities was relatively modest in both cases. The first held that the federal government could not force the States to take title to nuclear wastes. The second held that the federal government could not order State officials to conduct background checks on gun applicants. Yet both mandates were struck down for the threat they posed to the independent, sovereign status of the States.

That status is compromised to a far greater extent by Title II of the ACA, which combines the powers to tax and to spend to clobber States into submission. No matter what alternative they choose, there will be a substantial likelihood that the States shall be unable to comply with either of the two prongs of Title II and still be in a position to raise the revenues they need to discharge their essential police-power obligations. It is that Hobson's choice that requires the Court to strike down Title II of the ACA.

The first alternative given to the States is to continue to receive federal payments under the Medicaid program to cover their current obligations. But if they do so, they undertake at their own cost an extensive new set of obligations. Inter alia, they must set up an administrative apparatus capable of servicing the large population of low-income citizens under the program at State expense. The federal government has made no systematic effort to quantify the size of these financial obligations. Nor has it determined whether the States will be able to raise the revenues to discharge them while maintaining the core functions reserved to them under our system of dual sovereignty.

The second alternative leads to equally impermissible results. It allows the States to opt out of the current Medicaid program, but it continues to impose on its citizens their current tax obligations to fund the nationwide system of Medicaid. The State that grasps this horn of the dilemma will know that its citizens will be heavily taxed for the benefit of citizens in other States. Those continuing tax burdens will in turn preclude any opting-out State from imposing the large tax increases it will need to maintain its current level of support for its Medicaid population, most of whom are subject to the individual mandate, while discharging its other obligations.

This massive frontal assault to State sovereignty thus makes Title II of the ACA more vulnerable to attack than the modest programs that were invalidated in *New York* and *Printz*. It also explains why this case is easily distinguishable from the two cases on which the government will rest its case here. The modest 5% of revenues withheld from federal highway programs in *South Dakota v. Dole*, 483 U.S. 203 (1987), for States that did not raise their drinking age to 21 was a mere pinprick in the side of State government. The federal tax on employers that this Court upheld in *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937), posed no threat to State autonomy because it authorized each

State to establish its own unemployment-compensation programs, by refunding to any State that did so 90 percent of the federal tax it collected.

The key precedent of this Court for understanding the scope and limits of the spending power is still *United States v. Butler*, 297 U.S. 1 (1936). That case stands for the proposition that the power to tax and spend for the general welfare found in Article I, Sec. 8, cl. 1 does not allow the federal government to use its power to tax and spend as "the instrument for total subversion of the governmental powers reserved to the individual states." *Id.* at 75. The Congress may have the power under Article I, Section 8, Clause 1 to tax and to spend to "provide for the general Welfare of the United States," *id.* at 65, but it cannot use those two awesome powers in combination to undercut the ability of States to discharge their essential functions. To see why, note that the constitutional position would not change at all if the taking title obligation in *New York*, or the State police obligation in *Printz*, were attached to spending bills that forced the States to surrender billions of dollars if they did not assume these modest obligations. The federal government may not, within our system of federalism, "impose its policy preferences upon the States by placing conditions upon the return of revenues that were collected from the States' citizenry in the first place." *Virginia Dep't of Educ. v. Riley*, 106 F.3d 559, 570 (1997) (Luttig, J., dissenting). Were a State to refuse to comply with Congress's conditions, "federal taxpayers in [that State] would be deprived of the benefits of a return from the federal government to the State of a significant amount of the federal tax monies collected." *Jim C. v. United States*, 235 F.3d 1079, 1083 (2000) (Bowman, J., dissenting). The larger the amount of the funds conditioned, the less realistic the State's purported option of turning the funds down.

Nor can the federal government salvage its Medicaid program by resorting to the elusive distinction between "encouragement" and "coercion." The Court of Appeals admitted its inability to find some line between them. *Florida v. United States Dep't of Health & Human Servs.*, 648 F.3d 1235, 1264-66 (11th Cir. 2011). But wherever that precise line is drawn, any comprehensive scheme that makes it impossible for a State to preserve its fiscal independence no matter which horn of the dilemma it grasps has to be regarded as "coercive" under *Dole*. If the federal government wants to extend its welfare obligations to the extent proposed, let it do so through direct taxation and expenditures. It cannot leave the States in financial distress, whether or not they decide to participate under Title II. The all-too-forgiving rational basis standard cannot let Congress unilaterally dismantle the fundamental features of our federal system by the artful contrivances of the ACA.

The federal government's sledgehammer tactics illustrate anew how governments at all levels are all too willing to aggrandize powers in ways that undermine our constitutional order. Block the direct route of political abuse, and governments will look for novel ways to circumvent those restrictions. The spending power offers one dangerous strategy by which to circumvent the basic constitutional scheme. Absent a firm constitutional limit on Congress's ability to impose these same burdens through the spending power, all other efforts to constrain Congress and preserve Our Federalism would be for naught. A judicially enforceable outer limit on Congress's power to coerce States under the taxing and spending power is an irreducible constitutional imperative. If the ACA's heavy-handed expansion of Medicaid does not surpass that limit, no Act of Congress ever will.

ARGUMENT

I. Congress Cannot Use its Power to Tax and Spend to Subvert State Governments.

A. This Court's Spending and Taxing Decisions Recognize the Need to Preserve the Independence of State Governments.

Article I, Sec. 8 of the Constitution provides that "The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general

Welfare of the United States." The existence of the spending power, however, does not nullify the limited nature of Congress's power generally. In *U.S. v. Butler*, 297 U.S. 1 (1936), the Court held unconstitutional certain taxes imposed on agricultural processing when the revenues collected were transferred to other farmers who agreed to reduce the acreage and crops under cultivation. The provision consciously imposed a federal cartel on agricultural production, which surely lay outside the powers of the United States before the transformative case of *Wickard v. Filburn*, 317 U.S. 111 (1942). Congress at that time could not restrict the acreage under production. Hence under the then regnant rule in *Hammer v. Dagenhart*, 247 U.S. 251 (1918), it could not evade that restriction by substituting a tax for direct regulation. *Child Labor Tax Cases*, 259 U.S. 20 (1922). Accordingly, *Butler* observed that "if, in lieu of compulsory regulation of subjects within the States' reserved jurisdiction, which is prohibited, the Congress could invoke the taxing and spending power as a means to accomplish the same end, clause 1 of Section 8 of Article I would become the instrument for total subversion of the governmental powers reserved to the individual states." 297 U.S. at 75. As *Butler* notes, even Hamilton and Story, both strong nationalists, "never suggested that any power granted by the Constitution could be used for the destruction of local self-government in the states." *Id.* 297 U.S. at 77.

This logic remains impeccable today notwithstanding the broad expansion of the federal government under the Commerce Clause in *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937), and *Wickard*. So long as *United States v. Lopez*, 514 U.S. 549 (1995) places limits on the federal commerce power, conditional grants may not be used to work an end run around those limitations. As Justice O'Connor said in her dissent in *South Dakota v. Dole*, 483 U.S. 203, 216-17 (1987): "While *Butler's* authority is questionable insofar as it assumes that Congress has no regulatory power over farm production, its discussion of the spending power and its description of both the power's breadth and its limitations remain sound."

Disregarding the nontextual limitations of *Butler* lets the federal government undermine State sovereignty by one simple strategy consistently applied. First, tax the citizens of any given State to raise money. Second offer to return that money to the State only if it lets federal preference override local ones on core matters of State policy. The Medicaid provisions of the ACA pose just that threat: any State that refuses to make extensive expenditures of its own revenues will watch helplessly as the tax revenues from its citizens are diverted to those states that comply with the conditions. Withdrawing from the federal program leaves more revenues collected from its citizens for citizens of other states. Thus the Prisoner's Dilemma that forces all States to accept conditions that none of them want. This heavy-handed approach necessarily runs roughshod over the guarantees that the Tenth Amendment affords the States.

The risks of overreaching were evident enough in *New York v. United States*, 505 U.S. 144 (1992), where the Court struck down federal legislation that forced States to "take title" to unwanted nuclear waste products. The risks escalate exponentially when the entire system of State appropriations is put to a set of do-or-die choices by the ACA. As Justice O'Connor observed in *Garcia v. San Antonio Transportation Authority*, 469 U.S. 528, 588 (1984): "With the abandonment of *National League of Cities v. Usery*, 426 U.S. 833 (1976), all that stands between the remaining essentials of State sovereignty and Congress is the latter's underdeveloped capacity for self-restraint." *Id.* at 588 (O'Connor, J., dissenting).

Her views moved out of dissent in *New York*, 505 U.S. at 144. Writing for the Court, Justice O'Connor struck down part of a federal law that required States either to take title to low-level radioactive waste generated within their borders, or else to regulate its disposal according to Congress's instruction. "In this provision," she wrote, "Congress has crossed the line distinguishing encouragement from coercion." *Id.* at 175. Congress could not force states to choose between two alternatives neither of which Congress had the power to impose "as a free standing requirement." *Id.* "Accountability is . . . diminished when, due to federal coercion, elected State officials cannot regulate in accordance with the views of the local electorate in matters not preempted by federal regulation." *Id.* at 169. By definition any such "encouragement" diminishes a State government's responsiveness to local preferences in favor of national ones, regardless the degree.

The constitutional support of conditional federal grants grew still weaker in *Printz*, 521 U.S. at 898. Here, the Court struck down that part of the Brady Act that required State police to conduct background checks on prospective gun purchasers. The Court ruled that because the federal government cannot compel State governments to regulate, neither can it compel State officials in its executive branch to perform any particular function. *Id.* at 935. Justice Scalia, writing for the majority, rejected an balancing test as "inappropriate." "It is the *very principle* of separate State sovereignty that such a law offends, and no comparative assessment of the various interests can overcome that fundamental defect." *Id.* at 932 (emphasis in original, citations omitted).

Printz holds that if a federal law offends "the structural framework of dual sovereignty," *id.*, it is categorically unconstitutional. *Printz* revives the core proposition that the federal and State governments may defend their independent operating powers under this nation's "structural framework of dual sovereignty." Justice Scalia hammered this point home by invoking the Necessary and Proper Clause as a *limitation* on the power of the federal government. *Id.* at 923-24. A law that violates the federal structure of the Constitution is not "proper" for carrying into execution any enumerated power, "and is thus, in the words of the Federalist, 'merely [an] ac[t] of usurpation' which 'deserves to be treated as such.'" Id. (alteration in original) (quoting The Federalist No. 33 (Alexander Hamilton). *Printz* teaches that all States must remain "independent and autonomous within their proper sphere of authority." *Id.* at 928. The ACA crosses that fixed and visible line.

Bond v. United States, 131 S. Ct. 2355 (2011), affirms that hard-edged view by giving citizens standing to challenge federal violations of State sovereignty. Justice Kennedy, writing for the majority, reiterated that "'federalism secures to citizens the liberties that derive from the diffusion of sovereign power.'" *Id.* at 2364 (quoting *New York*, 505 U.S. at 181). The partition of government authority into two units "protects the liberty of the individual from arbitrary power." *Id.* For the first time since the New Deal, the Court had finally and emphatically equated unbridled national majority rule with "arbitrary power." *Id.* If the "structural framework of dual sovereignty" makes federalism an imperative bulwark against "arbitrary power," it does so whether the federal government overreaches through either its commerce or taxing power. Surely *New York* and *Printz* come out the same way even if each told the states to comply with its dictates on pain of losing all of its government funding for nuclear waste or gun control program.

More generally, if this Court holds that no conditional federal grant is coercive, then the only limits on the aggrandizement of federal power lies in the self-restraint of Congress—a commodity in very short supply. There is a close nexus between conditional grants and commandeering. What is needed is a clearer account of the permissible limits on government grants under *Butler* and *Dole*. In this inquiry, the one wrong answer is that the federal government can impose whatever limitations it chooses because the States must accept the bitter with the sweet. What is needed is some better metric to distinguish between permissible and impermissible conditions. Unless they are properly constrained, conditional grants pose a mortal threat to the diversity of responses that States can fashion for their own citizens.

B. The supposed distinction between the "denial of a gift" and the imposition of a "sanction" does not provide a suitable account of when the federal government can limit State powers to advance

federal purposes in ways that divert its citizens' tax dollars to other states.

The critical distinction between gifts and coercion has nothing to do with size of any attached condition, either in absolute or in relative terms. Rather, that distinction rests on whose resources are at risk when the condition is imposed. It is one thing for a person to withhold a gift of his own cash, property or services. After all, anyone can make a gift of his own money to another, either absolutely or on condition. Indeed to deny the possibility of a conditional gift (I will only make you a gift so long as you live in Texas) is to put all potential donors in an impossible all-or-nothing position. Similarly, the law recognizes the parallel distinction between a bargain and a sanction, for all bargains necessarily depend on mutually interacting conditions. Thus A may sell his property to B only on condition that he is paid $1,000 in cash first. If condition were regarded as illicit, commerce would grind to a halt.

The true distinction between gifts and sanctions thus rests on different grounds, namely, whether the property, service or cash of A was initially taken from B. It is not permissible for A to take B's car, only to demand $20,000, its market value, before it is returned. Those two steps of the transaction must be viewed as one, after which it now appears that B has been forced to pay A $20,000 just to end up where he began. But if A demands that B pay the cost that A incurred in order to care for B's straying cattle, the condition is now legitimate because the amount of amends is limited to the cost of providing services to B. *See, Marshall v. Welwood*, 38 N.J.L. 339 (1876), for the application of these rules in connection with cattle trespass. The same insistence informs the law of unconstitutional conditions. The demand is no longer naked extortion because it is tied to the cost of providing legitimate services.

When that justification is missing, A's threat remains illicit even if he does not seek to extort all that he can from B. Reducing the monetary demand for the return of a stolen object does not turn coercion into a gift. If it did, then the thief's royal road to coercion is to moderate his cash demands to a fraction of full value in negotiating the return of stolen property to its true owner.

These distinctions have constitutional dimensions. In *Dolan v. City of Tigard*, 512 U.S. 374 (1994), this Court recognized that it was appropriate to condition building permits on the willingness of the owner to compensate the State for the impact of its development. But it could not condition those permits on the willingness of the landowner, without justification, to rectify harms caused exclusively by other individuals. "Under the well settled doctrine of 'unconstitutional conditions,' the government may not require a person to give up a constitutional right--here the right to receive just compensation when property is taken for a public use--in exchange for a discretionary benefit conferred by the government where the benefit sought has little or no relationship to the property." Id at 385.

Texas and other States that oppose the Medicaid expansion provisions of the ACA are required either to spend their own money for causes they think unwise or surrender tax dollars to citizens of other States. Neither falls into the class of justifiable conditions. It is precisely because the funds in question come from their own residents that the threat of losing *any* sum of money to other States is, categorically, a sanction. The vast size of these proposed transfers only compounds the damages from the underlying illicit conduct. It should be evident that residents of Texas may well want nothing to do with the State policy preferences of California or New York. Conditional federal funding should not allow the latter's preferences to supersede those of the citizens of Texas with respect to wealth generated by the citizens of that State in areas that are within the State's proper sphere of authority, *Printz*, 521 U.S. at 928. The residents of Texas can vote their own State legislators and representatives in Congress out of office. But they cannot vote the legislators and representatives of other States out of office. Strip states of the power of their own purse, and by indirection vest that power in the citizens of other states, and the American constitutional ideal of free, equal and independent State sovereigns is brought to an end.

In addition, using conditional federal grants also imposes an unnecessary uniformity in areas that are best left State regulatory discretion. The ACA necessarily undercuts the State autonomy needed to function effectively as the "laboratories" of democracy. *New State Ice Co, v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). All too often, it is not evident what solution works best in any given area. Experimentation and interstate competition offer the best road to discovery. This is especially true in health care, which is marked by a dizzying diversity of approaches. It is desirable in our constitutional law for a minority of States to pursue those policies that they think will generate competitive advantage over other States. *See*, e.g., Lynn A. Baker, *Conditional Federal Spending and States' Rights*, 574 Annals 104, 109 (March 2001). Races to the top are good, even if races to the bottom are not.

Sorting out permissible from impermissible conditions involves the heavy overlap between public and private law set out above. Our Constitution is laced with terms like "freedom," "private property," and "contract," drawn from private law. Thus in *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972), the Court wrote: "Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as State law—rules or understandings that secure certain benefits and that support claims of entitlement to those benefits."

Likewise, the term "coercion" appears nowhere in the Constitution. Yet it lies at the core of the debate over unconstitutional conditions.

The prudent thief gives the victim the familiar ultimatum: your money or your life. If the offer is accepted, the threatener escapes prosecution for murder and the victim escapes losing his life. Both sides therefore gain from the surrender of the money.

Yet these coercive deals pose profound threats to the social order. In the ordinary bargain, every person may walk away unless the other agrees to his demands, withholding property that he already owns. The workable and categorical distinction between my property and yours is what allows ordinary bargaining to take place. In contrast, in the common case of duress the victim is given a choice between two things, your money or your life, *both of which he is entitled to as of right*. The different distribution of property holdings separates the two cases.

The same situation arises in contract settings. Suppose that A gives his cloths to B for cleaning for $10. Once cleaned, B demands $15 before their return. For clothes worth more than $15, A will acquiesce for the short term gain. But if this threat works, A can never again entrust his cloths for cleaning to the tailor. To preserve the operation of markets, the law lets A sue B for $5 even if he cannot forcibly grab back his clothes. Once again the forced choice between two entitlements marks the case as one of coercion, whether B demands a penny or a thousand dollars extra for the return of goods.

These well-settled contract principles teach how to impose meaningful limits on Congress's exercise of its spending power. "[L]egislation enacted pursuant to the spending power is much in the nature of a contract." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). Necessarily, formal compliance with the rules of offer and acceptance does not create a binding contract if a contracting party uses its dominant economic position to extract unfair concessions that it could never obtain in a competitive market. The closeness between the private law of duress and the doctrine of unconstitutional conditions is made evident in *United States v. Bethlehem Steel Corp.*, 315 U.S. 289 (1942), where the question was whether, at the height of World War I, the United States government could set aside its shipbuilding contracts on grounds of duress because its trading partner Bethlehem occupied a dominant position in the shipbuilding industry. The Court rejected that claim, but the dissent of Justice Frankfurter perceptively addresses the relevant issues:

> Fraud and physical duress are not the only grounds upon which courts refuse to enforce

> contracts. The law is not so primitive that it sanctions every injustice except brute force and downright fraud. More specifically, the courts generally refuse to lend themselves to the enforcement of a "bargain" in which one party has unjustly taken advantage of the economic necessities of the other. . . . It always is for the interest of a party under duress to choose the lesser of two evils. But the fact that a choice was made according to interest does not exclude duress. It is the characteristic of duress properly so called.

Id. at 326–27 (Frankfurter, J., dissenting) (internal quotations omitted). These principles apply with equal force, when the federal government holds all the high cards because of its the undisputed power to tax.

Bethlehem's account of voluntariness has constitutional dimensions. "Just as a valid contract requires offer and acceptance of its terms, '[t]he legitimacy of Congress's power to legislate under the spending power [. . .] rests on whether the [recipient] voluntarily and knowingly accepts the terms of the 'contract.'" *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (quoting *Pennhurst*, 451 U.S. at 17). These observations give workable form to the observation in *Dole* that a valid acceptance must be voluntary "not merely in theory but in fact." 483 U.S. at 211-12. State acceptance cannot be voluntary when the federal government abuses its admitted powers to tax and spend. *Dole* seeks to isolate that point when action becomes "so coercive as to pass the point at which 'pressure turns into compulsion.'" 483 U.S. at 211 (citing *Steward Machine Co.*, 301 U.S. at 590). But the key question is not the size of the imposition but the justification for its use. The justification was wholly lacking when Congress sought to attach *any* condition on grants that allowed it to dictate how States regulated the consumption of intoxicating spirits, a subject denied to the federal government by the 21st Amendment.

That public justification is also missing for Title II of the ACA. In those cases, the conditions are not imposed to require restitution of benefits or compensation for harm inflicted. Rather Title II uses artifice to govern State expenditures of their own funds, an action which under *New* York *and Printz* Congress could not compel directly.

Given the weakness of its theoretical foundations it is no surprise that the cases following *Dole* cannot pinpoint "the point at which pressure turns into compulsion." *Id.* at 211 (quoting *Steward Mach. Co.* 301 U.S. at 590). Because *Dole* only asks whether a given condition weakens freedom of choice a little or a lot, it substitutes a distinction of degree when a distinction in kind is needed. *Dole* conflates different levels of coercion with an imaginary distinction between compulsion and encouragement.

This is a logical fallacy. If the penalty involved is miniscule, there is still a little pressure, and freedom of choice is lessened; if the penalty is enormous, the actor still has freedom to choose, notwithstanding the greater pressure. As with the victim and the robber, either there is coercion in both cases or there is coercion in neither. It is no wonder that there have been academic calls for the reconsideration of *Dole. See* Lynn A. Baker, *The Spending Power and the Federalist Revival*, 4 Chap. L. Rev. 195–96 (2001).

C. The Act's Medicaid Expansion Provisions Coercively Change the Conditions Attached to Medicaid Funds in Mid-Stream.

Replacing Medicaid matching funds would require raising states to raise their general revenues by an average of 38 percent. Edmund F. Haislmaier, *Quantifying Costs to States of Noncompliance with the PPACA's Medicaid Expansion* 4, Heritage Foundation (January 12, 2012). As argued above, justification not size matters. But even by looking solely at the latter, this program coerces each State to forego funding its programs on education, environment, and a thousand other areas to meet the insatiable demands of the federal tax collector. Let the government replicate this program in other areas of traditional State control, and soon federal mandates will fully govern the expenditure of all State revenues.

The power of these conditions, moreover, is compounded because federal government now threatens to pull the plug on an existing program in which the States have already heavily invested. Indeed, this bold stroke involves the same misuse of power found in the duress of goods case outlined *supra* at 19. This Court has suggested that the freedom to comply or not comply with federal conditions must "remain[] the prerogative of the States not merely in theory but in fact." *Dole*, 483 U.S. at 211-12. Midstream changes are inconsistent with the preservation of State prerogatives. Recall that in *Butler*, 297 U.S. at 1, the Court explained the coercive effect of the Agricultural Adjustment Act of 1933: "The regulation is not in fact voluntary. The farmer, of course, may refuse to comply, but the price of such refusal is the loss of benefits. [...] This is coercion by economic pressure. The asserted power of choice is illusory." 279 U.S. at 70-71.

Notwithstanding the harrowing risks of imposing its Medicaid program, the federal government has never had to explain which, if any, of its many conditional spending programs would be jeopardized by applying the rules dealing with coercive conditions parallel to the common law rules on restraint of trade. *See*, *supra* at 27-28. We cannot envision which laws these might be. Since the risk of excessive invalidation is at a minimum, this Court should stop this Medicaid expansion before it allows the federal government to start usurping the powers of the States on a routine basis.

Our Federalism cannot long endure if its sole protection lies in Congress's "underdeveloped capacity for self-restraint." *Garcia*, 469 U.S. at 588 (O'Connor, J., dissenting). The vital constitutional balance must not be circumvented by repeated and ill-considered invocations of the federal spending power. Let that State of affairs become the new status quo and all limits on Congress's power are at an end. Anything that Congress could not achieve directly could now be achieved indirectly by attaching onerous conditions on federal funds that it raises through the use of its taxing power.

The demise of Our Federalism carries with it ominous consequences for the vitality of the nation. Federalism ensures that "States may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear." *Lopez*, 514 U.S. at 581 (Kennedy, J., concurring). That uncertainty is most definitely the norm in the provision of health care to the needy. The perils to vigorous State level innovation are still more dire for a spending program like Medicaid which is so massive that Congress and courts alike have come to recognize that "a complete withdrawal of the federal prop in the system ... could seriously cripple a State's ability to function," *Harris v. McRae*, 448 U.S. 297, 309 n.12 (1980) (internal quotation marks omitted). The implications of this vast imposition of federal control over traditional State activities are at best dimly understood. This Court should not let the Congress roll the dice in a single, ill-conceived experiment that will of necessity squash the multitude of intelligent experiments that routinely go on at the State level. It is not tenable for the Court to accept the federal government's naked assertion of unbounded power when its lawyers say, in ignorance of the historical traditions that have made this country great, that "Congress should be able to place any and all conditions it wants on the money it gives to the states," 648 F.3d 1267. Not if Our Federalism is to survive.

II. In Determining Which Conditions Constitute Coercion, Courts Should Be Guided by a Rule of Reason That is Widely Used in other Areas.

It is now possible to bring together the previous arguments into a single synthesis that guides the resolution of this case. It is widely understood that virtually all government appropriations are subject to conditions. It could hardly be otherwise. As noted above, the use of conditions imitates the results found with complex contracts in competitive markets where firms will only pay money for the goods and services that they desire, not just those goods and services that a vendor wishes to supply. Typically, the conditions will survive only if they work to increase the overall efficiency of the cooperative arrangements between two sides.

The one notable exception to this rule, hinted at in *Bethlehem Steel*, is for contracts in restraint of trade, which have long been condemned at common law. The basic outlines of that prohibition are found in *Mitchell v. Reynolds*, (1711) 24 Eng. Rep. 347 (Q.B.) 349; 1 P. Wms. 181, 186–87, which dealt with the ability of a buyer or an employee to engage in work in competition with his seller or employer once their relations are terminated. In this context, the general presumption—that the parties are free to strike whatever deal they chose for themselves—is displaced by a "rule of reason" under which courts examine any conditions that restrict the scope, time, and location the non-compete covenant. *See, e.g.*, *Jak Productions, Inc. v. Wiza*, 986 F.2d 1080, 1085 (7th Cir. 1994).

Two concerns drive the judicial oversight under this rule of reason, both of which inform the correct interpretation of *Dole*. The first is that some restrictions must be upheld if either business sales or employment contracts will work. No person will buy a business if he knows that his seller will go in competition with him the next day. Nor will any employer impart training and trade secrets to an employee who, upon quitting, could immediately compete with her the moment the employment is over.

Yet, by the same token, excessive restraints on any of the three dimensions of scope, time and geography could deprive consumers of the benefits of a competitive market. *Mitchell*, 24 Eng. Rep. at 349-50. No per se rule of legality or illegality therefore works, just as no per se rule of legality is faithful to *Dole*. Faced with the need to draw intelligent lines, the rule of reason empowers courts seek the fine balance between excessive and insufficient restraints on trade. For a historical discussion, see Harlan M. Blake, *Employee Agreements Not to Compete*, 73 Harv. L. Rev. 625 (1960). To say that the rule of reason is unintelligible is to dismiss antitrust law as a futile gesture, which it is not. That same level of respect for the rule of reason is necessary to make the doctrine of unconstitutional conditions work.

The rules about contracts in restraint of trade, discussed in connection with *Bethlehem Steel*, 315 U.S. at 289, of necessity require a distinction between conditions that seek to lever the control over one market into the control of another. The standard government conditions that restrict work to the purposes of a grant pose no problem in this regard. National Science Foundation grants can limit the field of research undertaken by an investigator. A government grant for a new road could specify where it is to be built. Even under Medicaid, federal government conditions can stipulate that the moneys received should be spent on certain classes of patients or diseases. These routine conditions are utterly beyond challenge as unconstitutional.

In contrast, Title II's efforts to regulate State activities outside the scope of the moneys granted have rightly provoked intense objection from the States. Fully implemented, these conditions pose an intolerable risk to State solvency and to the capacity of the State to discharge its normal police power obligations. The long-standing judicial condemnation of contracts in restraint of trade carries over with full force to these conditions when incorporated into a government grant.

Congress surely acts without justification when it denies any noncomplying State all the Medicaid dollars needed to run their own programs, without reducing by a penny the tax burdens on its citizens. Stripped to its essentials, the only choice left to the States that cannot afford to lose a fortune in Medicaid payments is to assume huge new liabilities dictated to them by the federal government, which causes them to lose that same fortune in yet another way.

This power of the federal purse is awesome. The only constraint on the exercise of that federal power kicks in only when the cost of complying with these conditions exceeds the billions of Medicaid dollars that the federal government can deny any individual States. No one yet knows whether Title II reaches that dangerous level. But what is known is that these onerous conditions have become wholly intolerable because the Medicaid provisions of Title II are linked to the individual mandate that Title I imposes on virtually all citizens. Without a Medicaid program in place, States will be put in the impossible position of having their neediest citizens lack the funds needed to comply with the federal mandate, thereby subjecting States with additional fiscal burdens.

III. *Dole* Has Failed to Offer States Any Protection from Federal Coercion.

A. None of the Four General Restrictions on the Spending Power Articulated in *Dole* Offer Any Protection from Coercive Grants.

The need for this rule of reason analysis becomes clear by an examination of the supposed limitations on the federal conditional spending power. The Court in *Dole* observed, "The spending power is of course not unlimited, but is instead subject to several general restrictions articulated in our cases." *Dole*, 483 U.S. at 207. The Court listed four: (1) the exercise of the spending power must be in pursuit of "the general welfare"; (2) the conditions must be unambiguously stated; (3) the conditions must be related to the federal interest in particular national projects or programs; and (4) the conditions cannot require the States to do something that is otherwise unconstitutional. *Id.* at 207-08.

None of these limits offer effective protection for State sovereignty.

First, in applying the "general welfare" prong, it is a mistake under *Butler* for federal courts to "defer substantially" to the judgment of Congress. Broad deference is inappropriate so long as Courts are charged with confining the federal government to its appropriate role. A high level of deference leads to the untenable position that these structural restraints are not judicially enforceable at all. *Id.* at 207 n.2. Behind the façade of *Dole* hides the federalism doctrine of *Garcia*.

Second, the restriction that conditions be unambiguously stated is orthogonal to the structural issues involved here. It merely sets a standard for statutory drafting. It does not advance any theory of justifiable conditions.

Third, requiring each condition bear a reasonable relation to the federal interest in a national project or program, has the potential for real teeth, as suggested by Justice Sandra Day O'Connor's dissent in *Dole*. It surely justifies all conditions that are use to constrain harms or to require offsets for benefits conferred. It is that last point that legitimates those conditions on how the states may spend the money supplied in a particular federal grant (which O'Connor thought permissible) and conditions that demand a State adopt a regulatory scheme contrary to its own interests (which Justice O'Connor thought impermissible). *Id.* at 216. The federal demand in *Dole* that states regulate the drinking age has nothing to do with the expenditure of federal highway funds.

Fourth, the bar against requiring states to do anything that is otherwise unconstitutional, is logically of no help because here there is no question of the validity of State policies; the challenge is rather the validity of the federal conditions that Congress creates for the purpose of shaping State policies.

B. The Ostensible Distinctions Between Gifts and Coercion, or Encouragement and Coercion are Conceptually Untenable

Other attempts to resuscitate *Dole* also fail. Thus *Dole*'s reliance on *Steward Machine* for the proposition that conditions may not pass "the point at which pressure turns into compulsion," 483 U.S. at 211 (1987) (quoting *Steward Mach. Co.*, 301 U.S. at 590), flounders precisely because *Steward* pays no attention to the distinction between the size of the condition and the threat it poses to Our Federalism. Instead, Justice Cardozo sought to draw this distinction: "[T]o hold that motive or temptation is equivalent to coercion is to plunge the law into endless difficulties. The outcome of such a doctrine is the acceptance of a philosophical determinism by which choice becomes impossible." 301 U.S. at 589–90.

Yet any purported similarity between motive or temptation and coercion is not the issue. What matters is the potential justification for the conditions imposed. By that test, the outcome in *Steward* is perfectly defensible without any deeper philosophical speculations. The key element in *Steward* was that the State imposed a tax to fund unemployment programs for individual citizens of that State. But it was prepared to return to each State 90 percent of the revenues collected so long as the State set up a similar program of its own. It is instructive to note that Justice Cardozo did not seek to overturn *Butler*, but scrupulously distinguished it on the ground that the expansion of the commerce power in *Jones v. Laughlin Steel* had knocked the props out from under *Butler*'s narrower reading of the Commerce Clause. *Steward's* return of the money to any State on setting up its unemployment program was not accompanied by any demand that these funds be spent on collateral purposes. Quite the contrary, the program minimized the cross-State transfer payments that make Title II the ACA a threat to the stability of the overall federal system.

C. Subsequent Readings of *Dole* in the Lower Courts Have Mistakenly Rendered the Doctrine of Unconstitutional Conditions a Dead Letter.

Amici are unable to find a single federal court of appeals case applying *Dole* that wasn't on appeal from the trial court's final judgment on either motion to dismiss or summary judgment. In other words, *Dole* has never led to a factual inquiry into the question whether the penalties involved in a conditional grant program "pass the point at which pressure turns into compulsion." 483 U.S. at 211. *Dole* stands for the proposition that the difference between encouragement and coercion is a matter of a degree. But the logical fallacy of that proposition is so profound that, apparently, no federal court has even tried to devise a standard for divining whether or where the line between encouragement and compulsion has been crossed.

In the decision below, the Eleventh Circuit acknowledged the internal difficulties of *Dole*. It wrote that this Court's coercion doctrine "is an amorphous one, honest in theory but complicated in application. But this does not mean that we can cast aside our duty to apply it; indeed, it is a mystery to us why so many of our sister circuits have done so." *Florida*, 648 F.3d at 1266. But it should come as no mystery why so many federal courts have "cast aside" their duty to apply *Dole;* it is virtually impossible to apply honestly or even coherently. For example, in *Pace v. Bogalusa City Sc. Bd.*, 403 F.3d 272 (11th Cir. 2005) Judge Bolusa asked, "If not now, and on this showing, when, on what showing, will federal grants be deemed unconstitutionally coercive?") (Bolusa, J., dissenting) (internal quotations omitted).

Because *Dole* wrongly turns on a question of degree, the decision cannot help determine where to draw the line. Since some conditions are obviously good, *Dole's* progeny have taken the easy way out by gutting the doctrine on appeal from either motions to dismiss or from summary judgment in the trial court. In no case has any district court ordered a full trial even when there were genuine disputes over matters of material fact on the question of whether the burden of the condition were too great. Those cases cannot be true to *Dole's* larger purpose, if all challenges to particular legislation were resolved in favor of the federal government as a matter of law *every time*, even when with material facts in dispute.

For example, just two years after *Dole* the Ninth Circuit rejected a coercion challenge against a federal law that conditioned 95 percent of federal highways funds on the states' acceptance of a national speed limit, in terms that seemed to reject *Dole* outright:

> [C]an a sovereign State which is always free to increase its tax revenues ever be coerced by the withholding of federal funds -- or is the State merely presented with hard political choices? The difficulty if not the impropriety of making judicial judgments regarding a State's financial capabilities renders the coercion theory highly suspect as a method for resolving disputes between federal and State governments.

Nevada v. Skinner, 884 F.2d 445, 448 (9th Cir. 1989). Other cases have taken the same line. Thus in, *California v. United States.*, 104 F.3d 1086 (9th Cir. 1997), the Court opined that "to the extent that there is any viability left in the coercion theory, it is not reflected in the facts of this record." Similarly in *Koslow v. Pennsylvania*, 302 F.3d 161, 174 (3d Cir. 2002) the Third Circuit held that the states' power to tax makes them "more than capable of preventing undue coercion through economic encouragement."

In short, despite its promising rhetoric, the federal courts have unambiguously tossed aside *Dole*'s coercion doctrine. Walking in the footsteps of *Garcia*, they have left the structural framework of federalism at the mercy of the federal taxing and spending power. In so doing, they have also ditched the doctrine of unconstitutional conditions. *See*, *Skinner*, 884 F.2d at 448; and *Okla. v. Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981). Such an outcome may have been unsurprising before *New York* and *Printz*, but those cases teach us that the structural framework of dual sovereignty is a judicially enforceable imperative of our Constitution.

D. The Lower Court Decisions In the Instant Case Have Misconstrued the Lessons of *Dole*.

In the trial court below, Judge Roger Vinson upheld the Medicaid provisions. 780 F. Supp. 2d 1256 (N.D. Fla. 2011). He confirmed the results noted above that that no federal court has ever found coercion in any case, no matter how onerous the conditions: "every single federal Court of Appeals called upon to consider the issue has rejected the coercion theory as a viable claim." *Id.* at 1268. Once the size of the conditions no longer mattered, Judge Vinson found it easy to ignore the many factual questions left unanswered on "on economic assumptions, estimates, and projections many years out." *Id.* at 1267. In light of the failure of federal courts to develop any applicable coercion standard, he concluded the government was entitled to judgment as a matter of law. *Id.* at 1269. His candid opinion was tantamount to admitting that *Dole* has no teeth at all, no matter how egregious the behavior of the federal government. Any inquiry as to when government actions "pass the point at which pressure turns into compulsion" no longer matters in either in theory or in fact. *See Dole*, 483 U.S. at 211-12.

The Eleventh Circuit affirmed that the proposition that Judge Vinson was right to decide the case without looking at its facts. Its own confession of intellectual impotence first acknowledged the duty to apply *Dole*, only to confess inability to do so:

> To say that the coercion doctrine is not viable or does not exist is to ignore Supreme Court precedent, an exercise this Court will not do . . . . If the government is correct that Congress *should*

> be able to place any and all conditions it wants on the money it gives to the states, then the Supreme Court must be the one to say it.

648 F.3d at 1266–67 (emphasis added).

Nonetheless, *each* of the reasons advanced by the Court of Appeals fails to negate the powerful case against Title II of the ACA.

The first reason developed by the Eleventh Circuit to salvage Title II states that "the Medicaid-participating states were warned from the beginning of the Medicaid program that Congress reserved the right to make changes to the program." *Id.* at 1267. But surely those warnings are of no consequence in this particular case, because at no point did they give the States any extra flexibility to escape the clutches of Title II of the ACA. The thief may give a warning that he will kill if his requests are not honored, but that choice itself, as Justice Holmes noted in *Union Pacific Railroad Co. v. Public Service Comm'n of Missouri*, 248 U.S. 67, 70 (1918), is evidence of the use of duress, not its negation. If they accept the grant, they are hit with onerous new obligations. If they reject the grant, their citizens still pay taxes into the federal treasury that work to the exclusive benefit of citizens of other States. In an ordinary contract situation, a power to alter or amend an established program is never regarded as a license for a party to change the rules of the game in whatever fashion it sees fit. No amount of notice renders a coercive choice any less coercive.

Second, the Eleventh Circuit underestimated the perils to the States when it claimed that "the federal government will bear nearly all of the costs associated with the expansion." 648 F.3d at 1267. That passage rings false because, if the burdens were as light as the Eleventh Circuit suggested, why such strong opposition from such a large number of States? Worse still, the point is factually incorrect. It ignores the heavy costs associated with new enrollees, the expanded costs of existing enrollees, and the large administrative costs needed to put the program into place.

Third, the Eleventh Circuit notes that the States have "plenty of notice"—four years in fact, from the time of signing—to decide whether to participate in the program. 648 F.3d at 1268. But this point just repeats in different guise the mistake in the Eleventh Circuit's first point. There is plenty of time, but nothing that can be done during that interval to escape the crushing burden under Title II.

Fourth, the Eleventh Circuit notes that "while the State plaintiffs vociferously argue that states who choose not to participate in the expansion will lose all of their Medicaid funding, nothing in the Medicaid Act states that this is a foregone conclusion. Indeed, the Medicaid Act provides HHS with the discretion to withhold all or merely a portion of funding from a noncompliant State." 648 F.3d at 1268. But the discretion conferred on HHS makes matters worse. It may be used to favor one State at the expense of another in ways that accentuate the wealth transfer among States.

In short, the Eleventh Circuit has fired blanks. Owing to the lack of a persuasive justification for the conditions imposed, "the point of coercion is automatically passed," *College Sav. Bank v. Fla. Prepaidpostsecondary Ed. Expense Bd.*, 527 U.S. 666, 687 (1999), when Congress premises a comprehensive regulatory scheme on the understanding that States have no choice but to participate. "In such circumstances, if in no others, inducement or persuasion" necessarily goes "beyond the bounds of power." *Steward Machine*, 301 U.S. at 591. Congress knew this well, for at no point did it even think of a fallback position for states that did not want to join the program.

CONCLUSION

For the foregoing reasons, this Court should rule that the Medicaid expansion provisions of the ACA are impermissibly coercive of State governments, and strike them down.

Respectfully submitted,

Richard A. Epstein
800 N. Michigan Avenue
Apartment #3502
Chicago, IL 60611
richard.epstein@nyu.edu
(773) 450-4476

Mario Loyola
Counsel of Record
TEXAS PUBLIC POLICY FOUNDATION
900 Congress Ave., Suite 400
Austin, TX 78701
(512) 472-2700
mloyola@texaspolicy.com

Counsel for Amicus Curiae

January 17, 2012

APPENDIX

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APPENDIX A

A total of thirty-six Members of the Texas House of Representatives have joined this brief as *amici curiae*. They are:

Rep. Jimmie Don Aycock, 54th district

Rep. Dennis H. Bonnen, 25th district

Rep. Cindy Burkett, 101st district

Rep. Angie Chen Button, 112th district

Rep. William A. Callegari, 132nd district

Rep. Warren Chisum, 88th district

Rep. Brandon Creighton, 16th district

Rep. Drew Darby, 72nd district

Rep. John E. Davis, 129th district

Rep. Joe Driver, 113th district

Rep. Rob Eissler, 15th district

Rep. Gary Elkins, 135th district

Rep. Dan Flynn, 2nd district

Rep. Richard L. Hardcastle, 68th district

Rep. Patricia F. Harless, 126th district

Rep. Linda Harper-Brown, 105th district

Rep. Jim L. Jackson, 115th district

Rep. James L. Keffer, 60th district

Rep. Tim Kleinschmidt, 17th district

Rep. George Lavender, 1st district

Rep. Ken Legler, 144th district

Rep. Tryon D. Lewis, 81st district

Rep. Sid Miller, 59th district

Rep. Jim Murphy, 133rd district

Rep. Ken Paxton, 70th district

Rep. Charles Perry, 83rd district

Rep. Jim Pitts, 10th district

Rep. Connie Scott, 34th district

Rep. Ralph Sheffield, 55th district

Rep. Todd Smith, 92nd district

Rep. Wayne Smith, 128th district

Rep. Larry Taylor, 24th district

Rep. Raul Torres, 33rd district

Rep. Paul D. Workman, 47th district

Rep. William Zedler, 96th district

Rep. John Zerwas, 28th district

AMICUS CURIAE BRIEF

Nos. 11-393 & 11-400

FILED
FEB 15 2012
OFFICE OF THE CLERK

In The Supreme Court of the United States

NAT'L FED. OF INDEP. BUSINESS, ET AL.,
Petitioners,
v.
KATHLEEN SEBELIUS, ET AL.,
Respondents.

STATE OF FLORIDA, ET AL.,
Petitioners,
v.
U.S. DEPT. OF HEALTH & HUMAN SVCS., ET AL.,
Respondents.

On Writs of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

BRIEF OF *AMICUS CURIAE* THE WASHINGTON AND LEE UNIVERSITY SCHOOL OF LAW BLACK LUNG CLINIC IN SUPPORT OF AMICUS CURIAE COUNSEL ON SEVERABILITY

Timothy C. MacDonnell
Black Lung Clinic, Room 106
Washington and Lee University
School of Law, Lewis Hall
Lexington, Virginia 24450
(540) 458-8562
(540) 458-8135 (Facsimile)
macdonnellt@wlu.edu

Counsel for Amicus Curiae

LANTAGNE LEGAL PRINTING
801 East Main Street Suite 100 Richmond VA 23219 (800) 847-0477

QUESTIONS PRESENTED

Whether it is evident that Congress, in light of its goal for systemic health-care overhaul, would have preferred no reform at all to a reform law without the individual mandate.

Alternatively, whether the Court should preserve section 1556 of the ACA because Congress would have preferred these provisions to survive from the Act's otherwise invalid parts.

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STATEMENT OF *AMICUS* INTEREST[1]

The Black Lung Clinic ("Clinic") is a legal ic at the Washington and Lee University School aw in Lexington, Virginia. The Clinic represents mer coal miners and survivors who are pursuing eral black lung benefits. The Clinic's clients are resented by a member of the law school faculty nsed to practice law who works closely with dents in the Clinic. Students evaluate claims; elop evidence; conduct discovery, depositions, and rings; and write motions, arguments, and ellate briefs. In attempting to collect benefits, ers and survivors face formidable teams of yers, paralegals, and doctors that the coal panies assemble to challenge these claims. The nic currently represents thirty-seven former coal ers and their spouses. Nineteen of these clients receiving benefits as a direct result of the nges to the Black Lung Benefits Act made in the ordable Care Act.

Section 1556 of the Act makes two major nges to the Black Lung Benefits Act. These nges remove limiting language to make it simpler disabled miners and their families to establish t they are entitled to federal benefits. First, 556(a) reinstates the fifteen-year rebuttable sumption, which presumptively entitles former

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Pursuant to Supreme Court Rule 37, no counsel for a ty authored this brief in whole or in part, and no counsel arty made a monetary contribution intended to fund the paration or submission of this brief. No person other *amicus*, its members, or its counsel made a monetary ribution to its preparation or submission. All parties e consented to the filing of *amicus* briefs and have filed rs reflecting their blanket consent with the Clerk.

coal miners to benefits if they have worked over fifteen years underground and have a totally disabling pulmonary disease. The second, § 1556(b), reinstates a continuation of benefits for surviving spouses whose coal-mining spouse was receiving benefits at the time of their death. The clients of the Clinic already have benefitted from these amendments: nineteen clients who are currently receiving black lung benefits will stop receiving those benefits if the Act is invalidated. Thirteen widows and six former miners, all of whom are receiving benefits, will be left without income on which they rely if the Act is struck down in its entirety. The Clinic has a profound interest in the possibility of the invalidation of the Act. If the Act is totally struck down it would adversely affect our clients; not only the ones currently enjoying benefits under the amendments, but all coal miners or surviving spouses who will bring cases in the future.

SUMMARY OF ARGUMENTS

The Affordable Care Act ("Act" or "ACA") marks an unprecedented expansion in federal government, while simultaneously transforming the health-care industry. Pub. L. No. 111-148, 124 Stat. 119 (2010). In that light, the Court must determine whether, if the individual mandate is struck, Congress would have preferred "no Act" to "an Act severed." The doctrines of separation of powers and judicial restraint curtail the Court's remedial power. The Act's text, purpose, and functionality show Congress's preference for "an Act severed" to "no Act." Legislative history and the day's political realities reaffirm such preference. The debate surrounding health-care reform highlights

ngress's true intention—to pass a reform measure
t expands coverage, transforms the health-care
lustry, and garners sixty votes in the Senate. The
does just that, even in the mandate's absence.
us, if the mandate is unconstitutional, the Court
uld sever it from the remainder of the Act in
ordance with Congress's intent.

Alternatively, the uniqueness of the ACA
sents the Court with another option. The Act,
pite drastically affecting health care, works as an
nibus package of reforms. Some are related to
lth care, some are not. Specifically, § 1556 bears
relation to either the individual mandate or
lth care generally. Thus this Court should sever
556 from the otherwise invalid ACA. In doing so,
Court works within both precedent and the
ameters of separation of powers and judicial
traint.

ARGUMENTS

I. The Court should sever the individual mandate from the remainder of the Act because Congress would have preferred "an Act severed" to "no Act" at all.

In assessing severability, the standard is well-
ablished: "Unless it is evident that the
gislature would not have enacted those provisions
ich are within its power, independently of that
ich is not, the invalid part may be dropped if what
eft is fully operative as a law." *Champlin Ref. Co.*
orp. Comm'n, 286 U.S. 210, 234 (1932). This test
two prongs: first, whether the remaining
visions are constitutionally valid and
ependently operative; second, whether it is

evident that Congress would not have enacted the law but for the unconstitutional provision. Throughout this analysis, the doctrines of separation of powers and judicial restraint guide the outcome. *See generally Regan v. Time, Inc.*, 468 U.S. 641, 652–53 (1984).

The first prong requires little attention here. This Court will decide whether the expansion of Medicaid is constitutional.[2] The remaining provisions are valid and the mandate's absence does not affect their operation. Yet if the Court deems the individual mandate unconstitutional, the focal question arises: Whether Congress would have preferred "no Act" to "an Act severed." *See Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999) ("The inquiry into whether a statute is severable is essentially an inquiry into legislative intent."). Four factors—text, purpose, functionality, and legislative history—require but one conclusion: "an Act severed."

Demand for overhaul, coupled with Democratic control in Congress and the White House, made health-care reform inevitable. *Cf.* Private Pet'r's Br. 2–5 (discussing the impetus for "[c]omprehensive change of the Nation's system" during the 2008 presidential election and thereafter). The only open issue turned on the

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[2] This brief does not presume the constitutionality of Medicaid expansion under amended 42 U.S.C.A. §§ 1396a, 1396d, which this Court will address in *Florida v. Department of Health & Human Services*, No. 11-400 (U.S. Nov. 14, 2011). Rather, this brief focuses on whether the individual mandate is severable from the remainder of the Act, excluding the Medicaid-expansion provisions.

ans. The 111th Congress would have passed this
, an Act without the mandate, or any other act so
g as it expanded coverage, restricted
criminatory practices, and garnered sixty votes in
Senate. *See* Robert Pear, *Senate Passes Health*
re Overhaul on Party-Line Vote, N.Y. TIMES, Dec.
2009, at A1. Only one thing is certain: Congress
uld pass reform. That was the reality of the
lth-care debate, and that was the reality of
igress's intent. Therefore, the remainder of the
must stand even if the mandate does not.

A. The doctrines of separation of powers and judicial restraint set parameters for the Court's relief.

The Court's severability analysis focuses on
appropriate remedy once a statutory provision is
ıck as unconstitutional. *See Ayotte v. Planned*
enthood, 546 U.S. 320, 329–30 (2006).
aration of powers, however, qualifies that
ıedy and requires courts to "act cautiously" as the
ling of unconstitutionality frustrates the intent of
elected representatives of the people." *Regan*,
U.S. at 652. Thus "court[s] should refrain from
alidating more of the statute than is necessary."
Anything more ignores the constitutional
ameters imposed by the separation of powers
trine. *Cf. United States v. Reese*, 92 U.S. 214, 221
75) (cautioning against the substitution of the
licial for the legislative department of the
ernment").

The Court also restrains itself and lets
ıgress fix constitutional infirmities. *See Ayotte*,
U.S. at 329–30. In *Ayotte*, the Court recognized

that, as members of the judiciary, "we restrain ourselves from rewriting [ ] law to conform it to constitutional requirements even as we strive to salvage it." 546 U.S. at 329 (internal quotations and citations omitted). The Court must "devise a judicial remedy that does not entail quintessentially legislative work" and leave the otherwise valid remnants for Congress to fix with its pen. *Id.*; *see also Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3162 (2010) ("[S]uch editorial freedom . . . belongs to the Legislature, not the Judiciary."). Preference is for severability, and judicial restraint ensures that outcome. *See Ayotte*, 546 U.S. at 329.

These doctrines taken together guide the Court in determining severability. In *Randall v. Sorrell*, 548 U.S. 230, 262 (2006), for example, the Court refused to sever unconstitutional provisions from Vermont's otherwise valid campaign-financing laws. Severance would have required the Court "to write words into the statute . . . , or to leave gaping loopholes . . . , or to foresee which of many different possible ways the legislature might respond to the constitutional objections [the Court] found." *Id.* Under such circumstances, Congress leaves courts no choice but to strike the entire law, and even the most reserved judge or Justice cannot rely on separation of powers or judicial restraint. But if the problematic statute poses few constitutional issues, the Court need only strike the problem, nothing more. *See Ayotte*, 546 U.S. at 329–330 (suggesting that clearly defined constitutional issues beget clearly defined line-drawing for severability) (citing *United States v. Nat'l Treasury Employees Union*, U.S. 454, 479 n.26 (1995)). The ACA, unlike the tute in *Randall*, follows this scenario.

The doctrines of separation of powers and icial restraint apply with equal force here. On hand, as discussed below, the Court is asked to ume its "legislative hat" and determine "What uld Congress Have Done?" *but for* the onstitutional provision. On the other, the Court st act with restraint. It must refrain from lating the "elementary principle that the same tute may be in part constitutional and in part onstitutional, and that if the parts are wholly ependent of each other, that which is stitutional may stand while that which is onstitutional will be rejected." *Brockett v. kane Arcades, Inc.*, 472 U.S. 491, 502 (1985) oting *Allen v. Louisiana*, 103 U.S. 80, 83–84 81)). And the latter "hat," the Court's own hat, is n throughout the analysis.

B. The remaining provisions of the Act are valid and operate independently without the individual mandate.

The first prong of severability, a threshold uiry, turns on the validity and operation of the aining provisions. *See United States v. Booker*, U.S. 220, 258–59 (2005). The Court need not ermine congressional intent "if the balance of the slation is incapable of functioning ependently." *Alaska Airlines, Inc. v. Brock*, 480 . 678, 684 (1987). Yet so long as the remaining visions are valid and "fully operative as law," the lysis proceeds. *Id.*; *see, e.g., Free Enterprise d*, 130 S. Ct. at 3161 (declaring the remaining provisions of the Sarbanes-Oxley Act as "fully operative" without much inquiry).

The remainder of the Act is both constitutionally valid and "fully operative as law" without the individual mandate. *Alaska Airlines, Inc.*, 480 U.S. at 684. Even the most contentious provisions—guaranteed issue, 42 U.S.C.A. §§ 300gg-1, 3, community ratings, 42 U.S.C.A. § 300gg, and the employer mandate, 26 U.S.C.A. § 4980H—"not only stand on their own" but "are independent of" the individual mandate. *Alaska Airlines, Inc.*, 480 U.S. at 689. The mere fact that the mandate is part of the Act's overall scheme does not affect the independent operation of the remaining provisions. This matter is clear, and satisfies the first prong of the severability analysis. *Cf.* Private Pet'r's Br. 42–60 (focusing argument on congressional intent—not whether the remaining provisions are "fully operative as law"); State Pet'r's Br. 36 (same).

C. Congress, through the Act, intended to provide widespread coverage, prohibit discriminatory insurance practices, and transform the health-care system, and the absence of the individual mandate does not disturb that result.

In early 2009, the federal government embarked upon an unparalleled attempt to reconfigure health care. Faced with exorbitant costs and forty-nine million uninsured Americans, a Democratically-controlled Congress passed the ACA through an equally unparalleled legislative process. This Act not only imposes an individual mandate but affects every aspect of this country's health-care

tem. Simply, the Act is pervasive. It reaches
m the federal government to municipalities, from
ltinational corporations to Main Street diners,
m insurance companies to individuals.
ditional areas of government involvement are
panded; new frontiers are crossed. The end
duct fundamentally alters this country's health-
e system, and the individual mandate serves as a
all measure of this massive reform.

Thus, the central issue: whether, if the
ividual mandate is struck, Congress would have
ferred "no Act" to "an Act severed." *See Free*
terprise Fund, 130 S. Ct. at 3162 (asking whether
ngress, faced with the unconstitutional provision,
uld have preferred "no act" to "an act severed");
tte, 546 U.S. at 330 (same); *Booker*, 543 U.S. at
(same); *Denver Area Educ. Telecomm.*
sortium, Inc. v. FCC, 518 U.S. 727, 768 (1996)
rality) (same); *Brockett*, 472 U.S. at 506–507
me). The answer is "no." Congress would have
ferred this Act, albeit without the mandate, to no
rm. The Act's text, purpose, and functionality
uire this conclusion; the legislative history
ndates it; and the political realities reaffirm it.
ween a Democratic president, whose platform
tered on overhaul, and Democratic
ermajorities in both Houses, health-care reform
happening irrespective of the individual
ndate. *See* President Barack Obama, State of the
ion Address to Joint Session of Congress (Feb. 24,
9), *available at*
p://www.whitehouse.gov/the_press_office/Remark
-President-Barack-Obama-Address-to-Joint-
sion-of-Congress ("[W]e can no longer afford to
health care reform on hold."); 155 Cong. Rec.

S13800 (daily ed. Dec. 23, 2009) (statement of Sen. Kaufman) ("Make no mistake, we need health care reform now. The status quo—what I call the present health care system—is simply unsustainable."). The challenging parties cannot prove that "it is evident" that Congress would have acted differently without the mandate, and this Court should preserve Congress's intent through severance. *See Alaska Airlines, Inc.*, 480 U.S. at 684.

1. To determine intent, the text itself provides the starting point. *See Booker*, 543 U.S. at 220; *see also Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 390–91 (2000) (Scalia, J., concurring) ("The *only* reliable indication of that intent . . . is the words of the bill that [Congress] voted to make law."). In *Alaska Airlines, Inc.*, the Court stated that "[t]he inquiry is eased when Congress has explicitly provided for severance by including a severability clause in the statute." 480 U.S. 685. In its absence, "silence is just that—silence—and does not raise a presumption against severability." *Id.* at 686

As the Eleventh Circuit aptly noted, the Act lacks a severability clause, even though such a clause was included in an earlier version of the bill. *See Florida v. U.S. Dept. of Health & Human Servs.*, 648 F.3d 1235, 1322 (11th Cir. 2011); *see also* H.R. Rep. No. 111-299, pt. 3, at 114 (2009), *reprinted in* 2010 U.S.C.A.A.N. 474, 537. The clause's removal, however, bears no affect, and it should not cut against severability. The Court favors severability in accord with separation of powers, and Congress's drafting materials acknowledge such preference. *See Brockett*, 472 U.S. at 504 (recognizing severability as the "normal" rule); *Florida*, 648 F.3d at 1322.

reover, “the ultimate determination of erability will rarely turn on the presence or ence of such a clause.” *United States v. Jackson*, U.S. 570, 585 n.27 (1968). Applying *Jackson*'s guage here, the lack of a severability clause ries little force generally. Even more, the sence or absence of such a clause” in an nacted version of the law warrants no weight.

The Act's text is telling in that, aside from the gressional findings at 42 U.S.C.A. § 18091, it kes no mention of the mandate or its lications. The Act does not cross-reference the ndate with the guaranteed-issue provisions or other section. *See* 42 U.S.C.A. §§ 300gg-1, 3. tead, the mandate textually stands alone. *Cf. ker*, 543 U.S. at 260 (severing the onstitutional provision along with “critical cross- rences”).

2. The statute's purpose further reveals gress's intent. *See New York v. United States*, U.S. 144, 186–87 (1992). “Common sense gests that where Congress has enacted a utory scheme for an obvious purpose, and where gress has included a series of provisions rating as incentives to achieve that purpose, the lidation of one of the incentives should not inarily cause Congress' overall intent to be strated.” *Id.* at 186. So long as “the great body of statute have operative force, and the force templated by the legislature,” the failure of one vision, although furthering that purpose, need take down the remainder. *Reagan v. Farmers' n & Trust Co.*, 154 U.S. 362, 396 (1984).

Health-care reform had two purposes: increase coverage and lower costs. *See* § 18091; 155 CONG. Rec. S12745 (daily ed. Dec. 9, 2009) (statement of Sen. Bacchus) ("The goal of health care reform is to lower costs and provide quality, affordable coverage to American families, businesses, and workers."). The Act, even without the individual mandate, does just that.

From the more significant provisions, such as the employer mandate and the creation of state exchanges, to the less, such as the extension of dependent coverage, the Act expands coverage to the uninsured and dissatisfied consumers. 26 U.S.C.A. § 4980H (employer mandate); 42 U.S.C.A. § 18031 (state exchanges); 42 U.S.C.A. § 300gg-14 (extension of dependent coverage). The Act accomplishes this in multiple ways, none of which hinges on the individual mandate. First, employer coverage, as a result of the employer mandate, will increase by 14.4 million insured individuals.[3] THE LEWIN GROUP, PATIENT PROTECTION AND AFFORDABLE CARE ACT

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[3] This number, however, is offset by 17.2 million who will lose employer coverage. *See* LEWIN GROUP 17. From an economic standpoint, employers will find it less costly to drop coverage and allow their employees to obtain Medicaid or premium subsidies through state exchanges. *Id.* Yet this shift is innocuous. Of the 17.2 million losing coverage, 8.6 million will receive premium subsidies in the exchange, 3.7 million will enroll in Medicaid, and 3.9 million will be covered in the exchange without subsidies. *Id.* Only 1 million will go uninsured. *Id.* Arguably, the net effect is de minimis and, if anything, highlights the significance of the employer mandate. Couple that with the small-business tax credits per 26 U.S.C.A. § 45R, and the employer mandate plays a substantial role in expanding coverage notwithstanding the individual mandate.

'ACA): LONG TERM COSTS FOR GOVERNMENTS, PLOYERS, FAMILIES, AND PROVIDERS 17 (2010) reinafter "LEWIN GROUP"], *available at* p://www.lewin.com/content/publications/LewinGro \nalysis-
ientProtectionandAffordableCareAct2010.pdf. eral factors account for this increase, such as new ployer penalty payments, lower premiums from elimination of health status ratings, and the new ployer tax credit. *See* LEWIN GROUP 17. The ividual mandate, however, affects none of these.

Second, state exchanges, implemented under 3031, will expand coverage through the creation n unprecedented open-market for insurance. *See* VIN GROUP i (referring to the Act's exchange as "centerpiece" of the legislation, which "presents sumers with a selection of health care coverage rnatives"). Through these exchanges, ividuals and small employers may compare and chase "qualified health plans"[4] as they deem ropriate—some of whom will receive premium . cost-sharing subsidies from the federal ernment. *See* CONGRESSIONAL RESEARCH :VICE, PRIVATE HEALTH INSURANCE PROVISIONS IN \CA (P.L. 111-148) 18 (2010) [hereinafter CRS, VATE HEALTH PROVISIONS]. According to the igressional Budget Office ("CBO"), approximately nillion people will obtain coverage through these ıanges. *See* CBO, SELECTED CBO PUBLICATIONS

"Qualified health plans" mean plans certified by the etary, which will provide a number of "essential health fits" prescribed by the Secretary, such as ambulatory ent services, hospitalization, and maternity and born care. *See generally* 42 U.S.C.A. § 18021.

RELATED TO HEALTH CARE LEGISLATION, 2009–2010, "Final Cost Estimate, March 20, 2010" 4 (2010) [hereinafter "CBO SELECTED PUBLICATIONS"], *available at* http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf. Although this number includes the individual mandate, it still highlights the significance of the exchanges' open-market effect. Moreover, the unprecedented nature of the exchanges follows Congress's demand for health-care overhaul. Regardless of the mandate, the mere availability of coverage through an open-market mechanism, such as the state exchanges, will create an influx of participants.

Third, the guaranteed-issue provisions bring in another portion of previously denied consumers, and guaranteed renewability maintains them. 42 U.S.C.A. §§ 300gg-1–3. These provisions operate independently of the mandate, albeit part of the same regulatory scheme. *But see* Resp't's Pet. 10, 31–33 (arguing that if the individual mandate is unconstitutional, the guaranteed-issue and community-rating provisions should fall as well). Displeased as insurance companies may be with severability, the inquiry focuses on the intent of Congress—not the insurance companies' preferences. In light of the impetus for systemic reform, the 111th Congress favored consumers over the insurer. The Act as a whole is a byproduct of that impetus and Congress's intent. *See, e.g.*, 155 CONG. REC. S13820 (daily ed. Dec. 23, 2009) (statement of Sen. Rockefeller) ("Reform is not about reaching perfect agreements on a perfect piece of legislation. Reform is making things better for people, as much as you can for as long as you can, with as much money as can possibly collect to pay for it."). The Court d not consider the insurance companies' nands, only Congress's purpose. And the Act ills that purpose even in the individual mandate's ence.

Concededly, the mandate's removal may affect overall cost-structure in light of Congress's goal educing the costs. Congress implemented the ndate, along with the guaranteed-issue and nmunity-ratings provisions, to expand coverage to isk individuals while containing the costs of miums. 42 U.S.C.A. § 18091(a)(2)(I) ("The uirement is essential to creating effective health urance markets in which improved health urance products that are guaranteed issue and do exclude coverage of pre-existing conditions can sold."); *see also* 42 U.S.C.A. §§ 300gg-1, 3 aranteed issue); 42 U.S.C.A. § 300gg (community ings). The removal of the mandate may upset the ply-demand structure, which otherwise would p premiums low. As a result, subsidies for hange purchases likely will increase, as will the ts of premiums outside the exchanges.

The severity of this effect is speculative, ever, and the Government misplaces its reliance t. *See* Resp't's Pet. 32. First, data are not ilable to determine the stress imposed on urers with the removal of the mandate. nittedly, empirical studies for states show a ative impact when insurers encounter similar ket reforms. *See, e.g.*, Mark A. Hall, *An luation of New York's Reform Law*, 25 HEALTH . POL'Y & L. 71, 91–92 (2000) (discussing how a e community-rating system caused some insurers to flee New York for fear of insolvency). On a federal level, however, multistate exchanges will increase the risk pool, thereby alleviating the impact of similar market reforms. Any analogy drawn between a state's experience and the projected impact federally is inapposite. Second, § 300gg(a)(2)(B) presumably enables the Secretary of Health and Human Services to assess community ratings state-by-state, with the ability to make adjustments. Both the states and the Secretary can adapt accordingly if the mandate's removal upsets the ratings system. *See also infra* Part I.C.3 (discussing administrative mechanisms that lessen the effects of the mandate's removal).

The mandate's absence also would have a de minimis effect as a revenue generator. The CBO estimates that the Act will reduce the federal deficit by $143 billion over a ten-year period from 2010–2019. CRS, PRIVATE HEALTH PROVISIONS 2. This reduction results from, among other offsetting measures, $17 billion in penalty payments for non-compliance with the individual mandate. *Id.* Absent this figure, the net cost of coverage provisions still would be $805 billion, up from $788 billion with the mandate, which is more than offset by other changes in spending and revenue under the Act. *Id.* Thus, absent the mandate, the Act still reduces the deficit by $126 billion. *Id.* The loss of $17 billion obtained from penalty payments, in this era of government spending, cannot render the Act contrary to Congress's purpose of reducing the deficit. Even so, the deficit still will be reduced without the mandate according to the CBO's calculations. *Id.* Furthermore, any emphasis on the revenue-raising feature of the mandate's penalty payments may be

ıplaced. The mandate's enforcement mechanism
ıws for nothing more than a tax refund
hholding. 26 U.S.C.A § 5000A(g). Such toothless
orcement cannot serve as a significant measure to
ıet costs.

Congress sought health-care reform under the
n goals of expanding coverage and lowering costs.
ɜ Act accomplishes these purposes, with or
hout the mandate. The challenging parties
not deny the extension of coverage. State
hanges will provide the means, while the private-
rket-insurance reforms will remove the hurdles.
reover, the employer mandate, coupled with
ɜll-business credits, will open health-care
erage for low-wage, yet full-time, employees. *See*
S, PRIVATE HEALTH PROVISIONS 7–10.
nittedly, the mandate's removal may affect
ıgress's goal of reducing costs. Without the
ndate, the guaranteed-issue and community-
ıngs provisions may stress the insurer and
/ernment's ability to cover costs, as well as the
rall supply-demand structure intended by
ıgress. 42 U.S.C.A. § 18091(a)(2)(C), (I). The
erability inquiry, however, focuses on Congress's
ɜnt, and whether it is evident that Congress
ıld have preferred "no Act" to "an Act severed."
Denver Area, 518 U.S. at 768 ("We can find no
son why [according to its objective] Congress
ıld have preferred no provisions at all to the
missive provision."). The Court's precedent
uires severability here, while the record
cludes any challenge to it.

3. The functionality of the statute without the
ıck provision serves as yet another guidepost for

legislative intent. *See INS v. Chadha*, 462 U.S. 919, 935 (1983). In *Chadha* for example, the Court severed § 244(c)(2) of the Immigration and Nationality Act, which unconstitutionally provided Congress with a one-House veto over the Executive's deportation stays. 462 U.S. at 931–35. In severing, the Court noted that the remainder of § 244(c) "survives as a workable administrative mechanism" to effectuate Congress's intent. *Id.* at 935.

Absent the mandate, the remainder of the Act functions both independently and according to Congress's goal of expanding coverage and regulating discriminatory practices. Significant provisions, such as the state exchanges, function independently of the individual mandate. Additionally, the Secretary retains substantial authority over the exchanges. 42 U.S.C.A. § 18031(c). This "administrative mechanism," *Chadha*, 462 U.S. at 935, enables the Secretary to adjust standards for the exchanges, including the issuance of plans, reinsurance, and risk adjustment, if the individual mandate is struck. *Id.* The guaranteed-issue and community-ratings provisions also further Congress's intent to rein in the insurance companies' discriminatory practices. And again, the Secretary presumably may adjust each state's ratings system absent the mandate. 42 U.S.C.A. § 300gg(a)(2)(B). These two "administrative mechanism[s]" ameliorate any distortion caused by the mandate's removal. *Chadha*, 462 U.S. at 935.

Furthermore, provisions that take effect before the individual mandate evince Congress's intent for swift and broad overhaul. *See* CRS,

VATE HEALTH PROVISIONS 3. To name a few: the
retary must establish a temporary high-risk pool
gram to provide coverage for eligible individuals
later than ninety days after enactment (42
.C.A. § 18001); insurers are prohibited from
inding coverage once an insured becomes sick,
ective six months after enactment (42 U.S.C.A.
0gg-12); insurers are prohibited from imposing
time benefits caps, effective six months after
ctment (42 U.S.C.A. § 300gg-11); and insurers
st allow young adults to stay on their parents'
n until the age of twenty six, effective six months
r enactment (42 U.S.C.A. § 300gg-14). The list
tinues. *See* CRS, PRIVATE HEALTH PROVISIONS
. A at 32–40 (detailing "immediate individual
group market reforms" that occur before the
ndate's implementation date, January 1, 2014);
also HHS, REDUCING COSTS, PROTECTING
NSUMERS: THE AFFORDABLE CARE ACT ON THE ONE
AR ANNIVERSARY OF THE PATIENT'S BILL OF RIGHTS
11).

The series of provisions that take effect before
mandate show a clear and definite intent of
gress: Start reform now. None of these
visions, or even provisions implemented after
uary 1, 2014, relies on the mandate. Rather, the
functions independently of the mandate. The
that it may not operate in the same manner is
the inquiry here. Instead, the proper inquiry
ses on Congress's preferred action without the
onstitutional provision. To scrap the entire Act
ld run counter to Congress's concerted effort to
nsform the health-care industry.

4. The legislative history, supplemented by the historical context and realties of the legislative bargain, reaffirms Congress's preferred action: "an Act severed" to "no Act." *See Alaska Airlines, Inc.*, 480 U.S. at 685 (evaluating importance of severed provision in the "original legislative bargain"); *Warren v. City of Charlestown*, 68 Mass. (2 Gray) 84, 99 (Mass. 1854). The bargain theory mirrors the inquiry into congressional intent. If the "statute created in [the severed provision's] absence is legislation that Congress would not have enacted," then the entire statute must fall. *Alaska Airlines, Inc.*, 480 U.S. at 685 (discussing "bargain theory" in severability analysis); *see also* Mark L. Movsesian, *Severability in Statutes and Contracts*, 30 GA. L. REV. 41, 60–62 (1995).

In *Warren v. City of Charlestown*, Massachusetts Chief Justice Lemuel Shaw drew upon the bargain theory as applied to severability. 68 Mass. (2 Gray) at 99. There, the state legislature enacted a statute annexing Charlestown to Boston, which took effect upon an affirmative vote of the city's inhabitants and certification by the mayor and board of alderman. *Id.* at 89–90. The mayor and board, however, maintained that some of the statute's provisions were unconstitutional and refused to certify the result. *Id.* at 85, 97. The inhabitants then sought a writ of mandamus from the state supreme court. *Id.* at 84. Chief Justice Shaw found against the plaintiffs, maintaining that the unconstitutional provisions were not severable from the otherwise constitutional provisions. *Id.* at 107. He noted that a statute could encompass both valid and invalid provisions, but:

> [I]f they are so mutually connected with and dependent on each other, *as conditions, considerations or compensations for each other*, as to warrant a belief that the legislature intended them as a whole, and that, if all could not be carried into effect, the legislature would not pass the residue independently, and some parts are unconstitutional, all the provisions which are thus dependent, conditional or connected, must fall with them.

at 99 (emphasis added).

As in contract law, the "conditions,
siderations or compensations" agreed upon by the
islature in *Warren* constituted a bargain. The
ence of any provision would have precluded
tual consent among the parties—that is,
mbers of the legislature. *See* Movsesian, *supra*,
1–63. The same applies to the 111th Congress
the ACA; only the individual mandate was not a
dition[ ], consideration[ ] or compensation[ ]"
essary for the legislative bargain. *Warren*, 68
ss. (2 Gray) at 99. Rather, the legislative history
ws that the public option, not the mandate, was
only issue precluding passage.

The challenging parties misinterpret the real
slative bargain here. *See* Private Pet'r's Br.
59. The individual mandate played a part in the
's passage, but so did the state exchanges, the
ranteed-issue provisions, the employer mandate,
dicaid expansion, and the community ratings. 42
.C.A. § 18031 (state exchanges); 42 U.S.C.A.

§§ 300gg-1, 3 (guaranteed issue); 26 U.S.C.A. § 4980H (employer mandate); 42 U.S.C.A. §§ 1396a, 1396d (Medicaid expansion) 42 U.S.C.A. § 300gg (community ratings). All were part of a "legislative bargain" sufficient for the seismic shift in health care. The Act, however, would have passed without any of them. For that matter, any law would have passed so long as it reformed health care and mustered sixty votes in the Senate. Those were the political realities of the day. The real legislative bargain thus turned on how the Act obtained sixty votes in the Senate. *See* Pear, *Senate Passes Health Care Overhaul on Party-Line Vote, supra* (discussing the Act's peculiar passage on a sixty-member, party-line vote in the Senate).

From the very outset, the individual mandate divided political parties. Yet Democrats could have passed reform, and ultimately did, without Republicans. The only variable existed among Democrats, and that variable was the public option. *See* Robert Pear & David M. Herszenhorn, *Senate Says Health Plan Will Cover Another 31 Million*, N.Y. TIMES, Nov. 18, 2009, at A1 (discussing the Senate's public option and the difficulty of obtaining sixty votes with it). Once Senator Reid introduced the Senate's initial health-care reform bill, which included a public option, he faced resistance immediately from fellow Democrats. *See* H.R. 3590, 111th Cong. § 1323 (Nov. 19, 2009) (unenacted version with public option). Senator Lincoln (D-AR) staked her position: "I am opposed to a new government-administered health care plan as part of a comprehensive health insurance reform, and I will not vote in favor of the proposal that has been introduced by Leader Reid as written." 155 CONG.

. S11933 (daily ed. Nov. 21, 2009). Senator drieu (D-LA) also lamented: "I remain concerned t the current version of the public option included his bill could shift significant risks to taxpayers r time unnecessarily." 155 CONG. REC. S11923– (daily ed. Nov. 21, 2009). After a month of osition to the public option, Senator Nelson (D- asked: "How do we bring it together so we can the high threshold of 60 votes in the Senate?" CONG. REC. S13078 (daily ed. Dec. 12, 2009). l thus the Senate leadership dropped the public ion, and the "legislative bargain" was struck. *See* vid M. Herszenhorn & David D. Kirkpatrick, *berman Gets Ex-party to Shift on Health Plan*, . TIMES, Dec. 15, 2009, at A1 (citing Senator berman's opposition to, and subsequent drop of, public option as the impetus for passage in the ate). Absent the option, the Act's passage was gone so long as reform was the result.

The Act was a bargain among legislators, and ncompassed a variety of reforms including the ividual mandate. The political realities, however, ited the bargain's participants to one party, and t party would have passed reform one way or ther. The breadth of reform depended on what ld muster sixty votes in the Senate. The only tingency was the public option. Without that, reform would have passed—anything that would e expanded coverage, reformed industry ctices, and garnered sixty votes. Although ificant, the individual mandate was not a dition[ ], consideration[ ], or compensation[ ]" for bargain. *Warren*, 68 Mass. (2 Gray) at 99. So if question arises whether Congress would have preferred "no Act" to "an Act severed," the legislative history provides the answer, "an Act severed."

II. The Court should preserve section 1556 of the ACA because Congress would have preferred these provisions to survive from the Act's otherwise invalid parts.

A. The Court has the ability and authority to sever valid provisions from the Act to protect Congress's intent and goals.

The Court's usual method of assessing severability is to apply the well-established, two-prong approach to determine if an invalid provision can be severed from an act, but this top-down method is not the Court's only option. The Court has the authority to look at statutes from the bottom-up and the duty to preserve as much of a law as it can. In keeping with judicial restraint, the Court has held that a single, constitutionally valid provision may be preserved and severed from an otherwise unconstitutional act. *See Denver Area*, 518 U.S at 767. The ACA is unlike any other the Court has examined. It is an unparalleled attempt to reconfigure health care. Most of the provisions are unrelated to the individual mandate, and do not affect personal insurance in any way. *See Florida*, 648 F.3d at 1322. The disparate and unconnected nature of the majority of the provisions of the Act should encourage the Court to use its authority to "sever" individual provisions to preserve them from invalidation.

In the case of *Denver Area Educational Telecommunications Consortium, Inc. v. FCC*, the

urt held, in a plurality decision, that a
stitutional provision of the Cable Television
nsumer Protection and Competition Act was
erable from unconstitutional provisions. 518 U.S
'67. The act in *Denver Area* contained three
visions "that [sought] to regulate the
adcasting of 'patently offensive' sex-related
terial on cable television." *Id.* The first provision
mitted the responsible cable operator to "decide
ether or not to broadcast such programs
eased access channels." *Id.* at 733. The second
vision "require[d] leased channel operators to
regate and to block that programming," and the
d provision permitted the responsible cable
rator to decide whether or not to broadcast such
grams on "public, educational, and governmental
nnels." *Id.*

The Court found that the first provision,
)(a), was constitutionally valid, and that the
ond and third provisions, §§ 10(b) and 10(c), were
onstitutional. *See id.* at 753, 760, 766. The
urt then addressed severability. Specifically, the
urt "ask[ed] whether § 10(a) is severable from the
other provisions." *Id.* at 767. As it always does
hese cases, the Court looked to legislative intent,
ing "[w]ould Congress still 'have passed' § 10(a)
l it known' that the remaining 'provision[s were]
alid'?" *Id.* (quoting *Brockett*, 472 U.S. at 506).
act in question had no severability clause, but
Court found "the [a]ct's 'severability' intention in
structure and purpose." *Denver Area*, 518 U.S. at
. The Court stated that as § 10(c) had "little, if
, effect" on the effectiveness of § 10(a), "its

absence . . . could not make a significant difference." *Id.*

Section 10(b), which required cable providers to segregate and block offensive programming, did affect § 10(a). *Id.* The Court found that this alone did not make § 10(a) "unseverable [sic]." *Id.* As long as Congress's goal was furthered, the Court stated that it could "find no reason why, in light of Congress' basic objective (the protection of children), Congress would have preferred no provisions at all to the permissive provision standing by itself." *Id.* at 767–68. Because § 10(a), even on its own, furthered the goal that Congress set out to achieve, it could be severed from the other two provisions that were found to be unconstitutional. *See id.*

The Court used its power to sever and followed "the normal rule that partial, rather than facial, invalidation is the required course," *Brockett*, 472 U.S. at 504, to sever a single provision from a larger scheme and two invalid provisions. *See Denver Area*, 518 U.S. at 767–68. In this way, the Court upheld the established principle that the "court should refrain from invalidating more of the statute than is necessary," and that it is "the duty of this court . . . to maintain the act so far as it is valid." *Alaska Airlines, Inc.*, 480 U.S. at 684 (quoting *El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909)). This is consistent with the well-established, two-prong test discussed above. *See supra* Parts I.B–C; *see also Alaska Airlines, Inc.*, 480 U.S. at 684.

In deciding that a provision is severable from er provisions, the Court's powers are limited. , *e.g.*, *Booker*, 543 U.S. at 258–59. The Court has ted that it "will sustain the statute only if it can alidly limited . . . and will strike it down if it not be so limited." *Id.* at 281 (Stevens, J., senting). If severing "would require the Court to te words into the statute" in order to make sense n act, it is "not possible to sever some of the t's . . . provisions from others that might remain y operative." *Randall*, 348 U.S. at 262. The rt has clarified further, stating "the onstitutional provision must be severed unless statute created in its absence is legislation that gress would not have enacted." *Id.* at 685. This ndard is further elaborated in *New York v. United tes*, in which the Court stated "[c]ommon sense gests that where Congress has enacted a tutory scheme for an obvious purpose, and where gress has included a series of provisions rating as incentives to achieve that purpose, the alidation of one of the incentives should not inarily cause Congress' overall intent to be strated." 505 U.S. at 186. If it cannot be shown t severance would go against the intent of gress, the Court should preserve individual, d provisions by severing them.

B. Section 1556 of the Act functions independently as law, and has no connection to the individual mandate or health care generally.

The amendments to the Black Lung Benefits ("BLBA") affect neither the individual mandate health care, but instead affect benefits available to coal miners who suffer from pneumoconiosis. *See* 30 U.S.C.A. §§ 921(c)(4), 932(*l*), as amended by ACA § 1556. Given that Congress has enacted this provision that is unrelated to the individual mandate, there is no reason to assume that it would not have enacted § 1556 without the individual mandate. If the individual mandate is found unconstitutional, the Court should sever §1556.

Section 1556 of the Act makes two major changes in the BLBA. The first reinstates a rebuttable presumption that existed prior to the 1981 Amendments to the BLBA. § 1556(a). The reinstated rebuttable presumption provides that miners who can establish that they were employed for fifteen years or more in an underground coal mine and suffer from a "totally disabling respiratory or pulmonary impairment" shall be entitled to a rebuttable presumption that coal mining substantially contributed to that disability. § 921(c)(4). Also, in cases in which a miner's surviving spouse can establish that the miner had fifteen years of underground employment and a totally disabling respiratory or pulmonary impairment at the time of death, there shall be a rebuttable presumption that coal mining significantly contributed to the miner's death. *Id.* The second major change reinstates a continuation of survivor benefits by striking "except with respect to a claim filed under this part on or after the effective date of the BLBA of 1981" from 30 U.S.C.A. § 932(*l*). § 1556(b). The continuation of benefits provides that eligible survivors of a miner who was receiving benefits at the time of his death are not required "to file a new claim for benefits, or refile or erwise revalidate the claim of such miner." 32(*l*). This second provision allows surviving uses to continue to receive benefits after their use has died without re-litigating their claim.

It is notable that in neither of these changes is urance mentioned or necessary. These changes e the burden on disabled coal miners and their viving spouses as they pursue benefits under the BA. Both changes reinstate law that existed long ore the individual mandate. Nineteen clients of Clinic are currently receiving black lung benefits to these amendments. These people will stop eiving the benefits they rely on if the Act is struck n entirely.

C. Congress would have preferred to preserve section 1556 rather than invalidate the entire Act.

As with the Cable Television Consumer tection and Competition Act described above, gress's intention of severability can be inferred n the ACA's "structure and purpose." *Denver a*, 518 U.S at 733. The Eleventh Circuit noted t "the lion's share of the Act has nothing to do h private insurance, much less the mandate that ividuals buy insurance." ***Florida***, 648 F.3d at 2. From this, it is clear that Congress intended ccomplish more with the ACA than simply ıdating insurance or "creating effective health ırance markets." *Id.* at 1323. Textually, the ndments to the BLBA are independent. Section 6 does not rely on or refer to any other section of ACA. Severing the amendments to the BLBA ı an unconstitutional provision would not require the Court to write words into the statute, as these provisions stand alone in the Act. *See Randall*, 548 U.S. at 262 (finding that a provision could not be severed if its removal required the Court to add to the statute to make it constitutional). Congress intended to provide miners with aid in receiving black lung benefits, and to ensure that eligible survivors of miners would not have to re-litigate their case to continue receiving benefits, whether or not they had personal insurance. *See* ACA § 1556; 30 U.S.C.A. §§ 921(c)(4), 932(*l*).

The argument may be made that Congress would not have passed the amendments to the BLBA without the individual mandate as part of the omnibus bill. That argument must fail. The sheer volume of provisions independent of personal insurance renders this argument ridiculous. The idea that Congress would rather throw away the entire law because of a single unconstitutional provision rather than allow independent provisions to survive not only strains logic, but is contrary to the Court's precedent. *See New York*, 505 U.S. at 186. Congress decided to join a large number of independent reforms together in an unparalleled, single law. As noted, the amendments found in § 1556 do not affect health care. To claim that Congress would prefer "no Act" to "an Act severed" would be to invalidate the entire omnibus of reforms, provisions, changes, and restorations simply because a single provision was unconstitutional. This extreme action would be acting counter to the goals and the intent Congress displayed in enacting this massive law, and would go against the principle of judicial restraint, as it is "the duty of this court . . . to maintain the act so far as it is valid." *Alaska* *ies, Inc.*, 480 U.S. at 684 (quoting *El Paso & ieastern R. Co.*, 215 U.S. at 96).

In the case of the amendments to the BLBA, ress is not making unprecedented changes, but ring limiting language. *See* § 1556; 30 U.S.C.A. 1(c)(4), 932(*l*). A claim made before 1981 ed the miner to both the presumption and the aatic entitlement for his survivors that are ssed above. 30 U.S.C.A. §§ 921(c)(4), 932(*l*). mendments found in the ACA merely extend entitlements to miners and their survivors who claims "after January 1, 2005, that are ng on or after" March 23, 2010. § 1556(c). The that Congress would have preferred to strike provisions rather than to have them without idividual mandate cannot stand. The sions have already existed long before the ate, or any other provision of the Act.

The legislative history of § 1556 is limited, but or Byrd's comments about the BLBA dments are enlightening. Senator Byrd states [i]t is clear that the section will apply to all s that will be filed henceforth," and clarifies he section is meant to "benefit all of the ants who have recently filed a claim." *See* 156 . REC. S2084 (daily ed. March 25, 2010) ment of Sen. Byrd). The history available ites that the amendments to the BLBA are led to take effect immediately. Nineteen s of the Clinic already rely on these changes. idividual mandate has not yet taken effect, ng further that Congress's intent in passing dividual mandate was unrelated to its ation in passing § 1556. For this reason, the claim that Congress would not have enacted the amendments to the BLBA without the individual mandate holds no water. Congress has allowed miners these rights prior to the ACA's enactment, and extends these rights not only to "all pending claims" but also to "all claims that will be filed henceforth." *See* 156 CONG. REC. S2083-4 (daily ed. March 25, 2010) (statement of Sen. Byrd).

The Court has the power to sever valid provisions of the ACA. *See Denver Area*, 518 U.S at 767–68. If a portion of an act is found to be unconstitutional, it is the duty of the Court to protect and save as much of a statute as can be salvaged. *See, e.g., Alaska Airlines, Inc.*, 480 U.S. at 684–86. Unless it is clear that Congress would have preferred total to partial invalidation, partial invalidation is the rule. *See Brockett*, 472 U.S. at 504. In order to uphold these principles and honor the intent and desire of Congress, the Court should sever and preserve § 1556 should the individual mandate be found to be unconstitutional and not severable.

CONCLUSION

If this Court deems the individual mandate onstitutional, Congress would have preferred "an severed" to "no Act" at all. Thus, the Eleventh cuit's judgment on severability should be irmed. Alternatively, if the individual mandate is severable, this Court should sever § 1556 from otherwise invalid ACA. Both remedies comport h precedent and follow the Court's doctrines of aration of powers and judicial restraint.

Respectfully submitted,

Timothy C. MacDonnell
Black Lung Clinic, Room 106
Washington and Lee University
School of Law, Lewis Hall
Lexington, Virginia 24450
(540) 458-8562
(540) 458-8135 (Facsimile)
macdonnellt@wlu.edu